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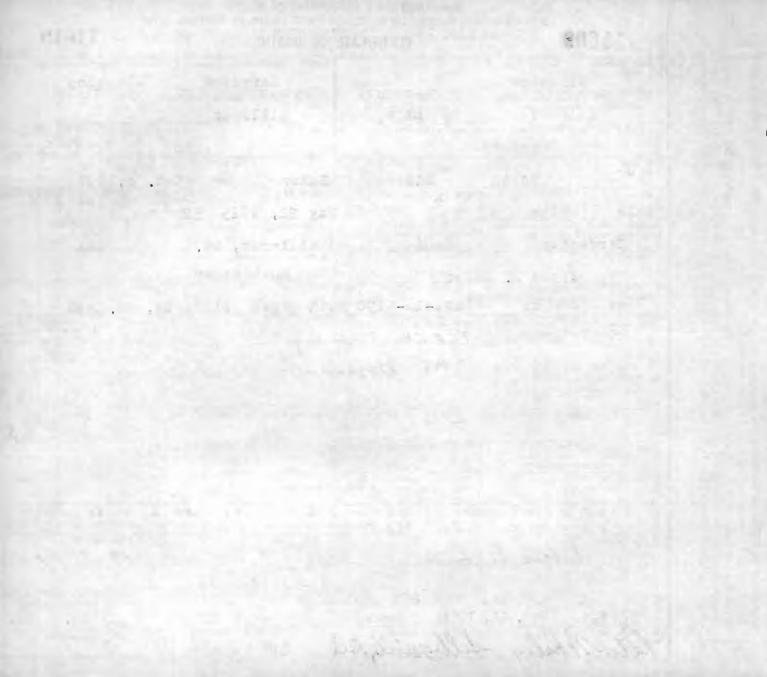
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items 23B, 23c CERTIFICATE 14619 death. 24 hours after death of in by the funeral pers. Pages 1 and 2 m/72 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE Wicomico Maryland Wicomico MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) C. LENGTH OF STAY IN 1h c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) Willards Life e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS XX YES NO OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within event with Middle 3. NAME OF First 4. DATE Last Manth Day Year DECEASED OF Edwin Milton Baker (Type or print) COF DEATH Oct. IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH AGE (In years NEVER MARRIED ease remaye last birthday) Months Hours and in any WIDOWED Male White DIVORCED pup 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11, BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired)
Carpenter physician con please INDUSTRY COUNTRY? Willards.

14. MOTHER'S MAIDEN NAME House Met TS A 13. FATHER'S NAME burial, crematian, or removal, attending phys Ruth Baker James 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address permit. (Yes, na, ar unknown) (If yes give war ar dates af service 221-16-5190 Ruth Baker Willards, Md. RFD INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit ONSET AND DEATH IMMEDIATE CAUSE (a) 'O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the hospital ar attending physician. **DUE TO** Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying cause airectar, page 3 shauld be detached far use as the shauld be filed with the State Dept. of Health priar ta this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? NO 200. ACCIDENT WAS UNDERLYING [20b, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Month, Day, Year (City or town) (County) (State) Hour 'p.m. factory, street, office bldg., etc.) 10 at wark TO FUNERAL DIRECTOR: After , 1969 , to 80 21. I certify that (1) (this haspital) attended the deceased from 2-2-_, 1962, that (1) (we) last saw the deceased alive an 7 - 30 - 1962, and that death accurred at 5-10 M, fram causes and an the date stated above. 22a. SIGNATURE 22b. DATE SIGNED STAFF PHYS. DIRECTOR M.D. 22d. ADDRESS 22t. PHYSICIAN'S Buli me NAME (Type) 23d. tOCATION (City or Town) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23g. BURIAL, CREMATION (County) (State) REMOVAL (Specify) Oct. 11 Bethel Willards Wic-Md. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS 2Sq. REC'D BY REGISTRAR VR A15 (4) 25M 1/67



	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
FOR STATE	14619	620				
delay is and 3 to HEALTH DEAL.	1. PLACE OF DEATH O. COUNTY LUICOINIY b. CITY OR TOWN (If outside corporate limits, write RURAL and give n	SSEX				
If Uny de urm PM3 Bepartm Urs after	write RURAL and give peorest town) SALISBURY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) PENINSULA GENERAL HASPITAL OURAL	e. IS RESIDENCE ON A FARM? YES NO				
32	3. NAME OF DECEASED (Type or print) S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BRTH 9. AGE (In years left under 1 years) 1. SEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years left under 1 years) 1. SEVER MARRIED 1. Middle 1. DATE 1. DATE	Doy Year 18 1967				
hin 24 haurs ncil in Item I niner's Office pages land 2' in any event	WIDOWED DIVORCED 3-1-98 Hg yrs	EN OF WHAT				
scuted withing" in pencedical Examiration promit. File po	RICHARD WARREN BANKS ORNA DELIGHT BANK 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) 173-10-7982 TRENE H. BANKS, FRANKFOR	SO, DELA.				
INER: This certificate shauld be executed within 24 haurs after the certificate, writing the ward "pending" in pencil in Item 18. Give should be farwarded to the Chief Medical Examiner's Office along files. 3 should be used as a burial-transit permit. File pages land 2 with the prior to burial, cremation, ar remaval, and in any event within	18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o). DUE TO Conditions, if any, which gove rise to immediate cause (o), stating the underlying couse (c) last. (c)	INTERVAL BETWEEN ONSET AND DEATH				
te, writing farward to used on the burial to the tenth of	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED? YES NO				
certifica auld be es. should b	200. EXTERNAL CAUSE WAS PRIMARY FOR CONTRIBUTING CAUSE OF DEATH. 201. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port L or Port II of item 18.) 202. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port L or Port II of item 18.) 203. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port L or Port II of item 18.)					
rcal Examiner: e execute the certification. Page 4 shauld hed for your files. ECTOR: Page 3 should have agent, pri	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County Hour o.m. 10-15 1967 While of work of	Del.				
no DEPUTY MEECAL EXAMINER: This necessary, please execute the certificate, the funeral director. Page 4 shauld be fe 5 may be retained far yaur files. To FUNERAL DIRECTOR: Page 3 should be Health ar its designated agent, priar ta	death resulted from: Natural causes Accident Suicide , Hamicide , Undetermined manner CHIEF MEDICAL EXAMINER	and in my opinion 22. DATE SIGNED				
To DEPUTY MEDICA necessary, please ex the funeral director. S may be retained for O FUNERAL DIRECTO Health ar its design.	SIGNATURE EXAMINER'S NAME (Type) A. T. M.S. Ley A. T. M.S. Ley Address (Street, city, town, or county)	16-18-67				
VR A15ME (5)	230. BURIAL CREMATION, PRIMOVAL (Specify) 24. FUNERAL MIRECTOR 25. MARKE OF CREMETERY OR CREMATORY 26. MARKE OF CREMETERY OR CREMATORY 27. MARKET OF CREMETERY 28. REC'D BY REGISTRAR 28. REC'D	SSEX DEZ.				

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14621 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH BEPT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY Wicomico a. COUNTY Wicamico Maryland MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If gutside carparate limits, write RURAL and give negrest tawn) and Eden Delmar d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e. IS RESIDENC d. STREET ADDRESS Do ON A FARM? Route # 2 YES NO [Connelly Mill Rd. Railroad Crossing in Item 18. Give Pages 24 haurs after death. 3. NAME OF First. DATE Last Year DECEASED (Type of print) DEATH 10-20-67 Waslev Ermest IF UNDER 24 HRS S SEX 9. AGE (In years 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B. DATE OF BIRTH last birthday) Manths Days Hours 72 hours after deoth poges lond 2 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during mast of warking life, even if retired KAGIOHAN 2Nd pencil 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no. or unknown) (If yes give war or dates of service event within IB. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c). buriol-tronsit PART I. DEATH WAS CAUSED BY: Crushed chest IMMEDIATE CAUSE (o) This certificate shauld the certificate, writing the word DUE TO No Canditions, if any, which gave rise ta immediate cause (a), DHE TO stoting the underlying couse 19. WAS AUTOPS) PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) or removol, CERTIFICATION NO X be 200. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 3 should plnods CAUSE OF DEATH Driver of car that collided with freight train. cremotion, MEDICAL 20d. INJURY OCCURRED 1 20e. PLACE OF INJURY (Hame, form, 20c. TIME OF INJURY Month, Day, Year (City or tawn) (State) Nat While RR foctory, street, affice b 11:35 Pm.M. 10-20167 foctory, street, affice bldg., etc.) Delmar Wicomico 21. I certify that I took charge of the remains described above, held an Autopsy ... Inspection X Inquiry X and in my opinion DIRECTOR: Accident X Suicide Undetermined manner death resulted from: Matural causes Homicide be retained pleose CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE FUNERAL DEPUTY MEDICAL EXAMINER Earl L. Royer, M.D. 10-23-67 Address (Street, city, tawn, ar county) Heolth Sal Talenty Me CREMATORY 23d. LOCATION (City or Town) 0 PRING H: 11 NEMONY GARDEN SALISBUM -Wico, Hd VR A 15ME

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) the attending physician and campletely filled in by the funeral sit permit. Then please remave carban papers. Pages I and o. COUNTY o. STATE b. COUNTY Wicomico MARYLAND hours after r LENGTH OF STAY IN 16 b. CITY OR TOWN (.I autside carporote limits, c. CITY OR TOWN (If autside carparate limits, write RURA), and give nearest town) Washington d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in haspitar, give street address) IS RESIDENCE ON A FARM? 2707 Adams Mill Road Peningula General Hospital NO K within NAME OF First Muddle DATE Day Year DECEASED John Dorsey 19 6 (Type or print) DEATH oher IF UNDER 24 HRS S SEX 6 COLOR OR RACI DATE OF BIRTH AGE (n years 7. MARRIED X NEVER MARRIED lost-burthday) Months Days Hours WIDOWED DIVORCED 12 CITIZEN OF WHAT BIRTHPLACE (County & State or fareign country)
Wicomico Maryland KIND OF BUSINESS OR 100 USUA, OCC. PAT ON (Give kind of work done INDUSTRY 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal. Emma May McKnett 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no. or unknown) (If Mrs. John D. Bassett, Washington, D.C. 218-16-5105 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) PART | DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH burial-transit cerebral metastisis IMMEDIATE CAUSE (o) **DUE TO** IN decell cancinoma mas Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause as the Page 4 may be retained by the haspitol ar attending TO FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? 3 should be detached far use with the State Dept. af Health p Carcinomo NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING ! OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) Hour o.m. Nat While factory, street, office bldg., etc.) ot wark 21. I certify that (1) (this hospital) ottended the deceosed fram Quag ZZ, 1961, to Qc + 7, 1967 that (1) (we) lost 19 67, and that death accurred at 7:40 PM, fram causes and an the date stated above saw the deceased olive on Cocx 22b. DATE SIGNED 22a. SIGNATUR **ATTENDING** M.D. PHYS DIRECTOR PHYS. directar, page 3 shauld be filed v 22d APDRESS 22c PHYSICIAN S Piace Blu NAME (Type) ISBUR, MARYIAN NAME OF CEMETERY OR CREMATORY 23b DAJE THEREOF (County) 230. BURIAL CREMATION (Stote) Firemen's Sharptoun, NEWNAM & SON, Sharptoun, Md. 2So REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE world VR A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH

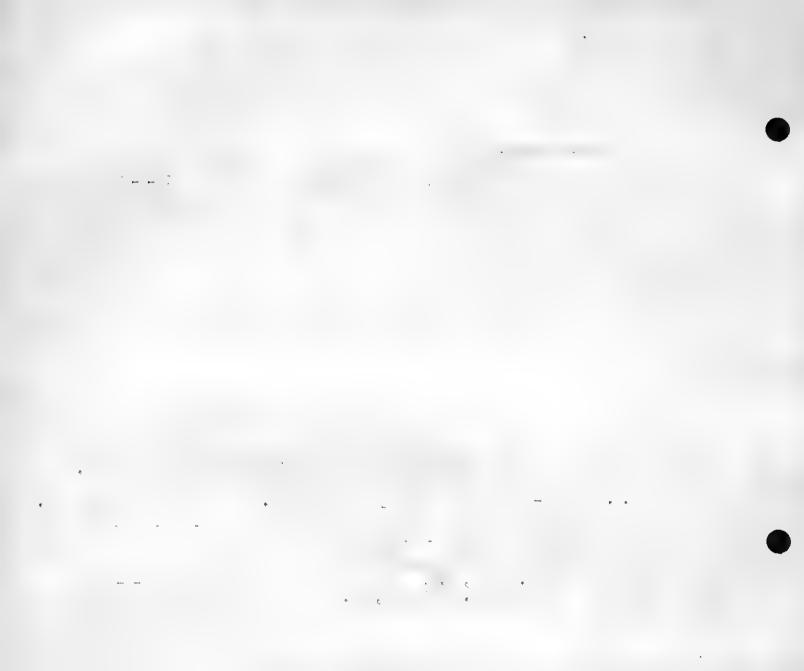


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 74614 14624 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b COUNTY Maryland Wicomico MARYLAND 36 c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) b CITY DR TOWN (if outside carparate imits, c LENGTH OF STAY IN 1b write RURAL and give nearest tawn)
Salisbury Salisbury d NAME DE HDSPITAL OR INSTITUTION (If not in hospital, give street aggress) d. STREET ADDRESS e IS RESIDENCE ON A FARM? farm 22h West Main Street in pencil in Item 18. Give Pages Peninsula General Hospital NO X This certificate shauld be executed within 24 haurs after death Office along with 3 NAME OF Middle 4 DATE DECEASED OF DEATH James 10-29-67 (Type or print) Bivens S SEX 9 AGE (In years IE UNDER 24 HRS 6 CDIDR DR RACE B DATE DE BIRTH IF UNDER 1 YEAR 7 MARR ED NEVER MARRIED last pirthdoy) WIDOWED X DIVORCED 100 USUA, DCCUPATION (Give kind of work done 10b KIND DE BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if refired) INDUSTRY COUNTRY? farwarded to the Chief Medical Examiner's 13. FATHER'S 14 .MDTHER'S MAIDEN NAME 16 SOCIAL SECURITY NO 17 INFORMANT ves give war or dates of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) event PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove nse to immediate couse (o), ⊆ DUE TO stoting the underlying couse or remaya, 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGN EXCANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART I(g) 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HDW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18) PRIMARY OF CONTRIBUTING CAUSE OF DEATH TIME DE N. RY Month, Doy, Year 20d INJURY DCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) Not While foctory, street, office bldg., etc.) 21 I certify that I taak charge of the remains described above, held an Autopsy ... Inspect an 📆 Inquiry T and in my opinian death resulted from: // Notural causes 🔽 Accident 📗 Suicide 🗍 Hamic'de Undefermined mainer CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER Royer, 10-30-67 Health | Address (Street, city, town or county) NAME ,Type Ave. Salisbury. CREMATION 0 VR A15ME (5)



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14625 FOR STATE HEALTH DEPT. 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) PLACE OF DEATH b. COUNTY Wicomico o. COUNTY Maryland Wicomico MARYLAND deoth Department c CITY OR TOWN (I autside carparate imits, write RURAL and give nearest town) C LENGTH OF STAY IN b b CITY OR TOWN (If outside corporate I mits. write RURAL and give nearest town) after Salisbury Salisburv d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) ON A FARM? hours orm Rt. 5, Spring Hill Road Spring Hill Road, Rt. 5 YES NO the State within 24 hours after death 4 DATE with Middle Month Day Year 3 NAME OF Eirst DECEASED 1967 October 23 BISHOP BOWEN. SR. WILMER DEATH within (Type or print) olofig IF JNDER 1 YEAR I IF UNDER 24 HRS ZIIX AGE (In years DATE OF BIRTH S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED birthday) Hours Oct. 1, 1893 in pencil in Item 18 DIVORCED White WIDOWED Male event lond2 forwarded to the Chief Medical Examinar's Office 12. CITIZEN OF WHAT 1) BIRTHPLACE (State or foreign country) 10b K ND OF BUSINESS OR 10a, USUAL OCCUPATION (Give kind of work done Board of Education - Newark, Maryland COUNTRY? during most of working life, even if retired) Retired-teacher & principal gny poges in any 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME Ella Bishop Samuel T. Bowen File puo 17. INFORMANT Irene F. Mrs. Irene F. Bowen (Wife) Rt. 5, Spring Hill Road, Salisbury, Md. IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO This certificate should be executed permit. or removel, (Yes, na, ar unknown) (If yes give war or dates of service) 213-14-1288 Yes War INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line logic), (b), and (c).) SEL AND DEATH buriol-tronsit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (g) writing the word DUE TO cremation, Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause 0 burial, WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND TON GIVEN IN PART I(g) NO X please execute the certificate, its designated agent, prior to pe 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I) of item 18.) 20a EXTERNAL CAUSE WAS CFRTIF 3 should PRIMARY I or CONTRIBUTING I **EXAMINER:** CAUSE OF DEATH. MEDICAL 20f (City or town) (County) (Stote) 20e PLACE OF INJURY (Home form. 20c TIME OF NJURY Manth, Day, Year 20d INJURY OCCURRED factory, street, office bldg , etc.) Hour am. Nat While FUNERAL DIRECTOR: Page at work of work 21 | certify that Ligan charge of the remains described above, held an Autopsy Inquiry X Inspection X and in my opinion 5 Undetermined manner Homicide director. depth resulted from: Natural causes Accident Suicide | retoined CHIEF MEDICAL EXAMINER 22. DATE SIGNED **ACTUAL** ASSISTANT MEDICAL EXAMINER **SIGNATURE** the funeral October 24 1967 DEPUTY FUNERAL Health or i DEPUTY MEDICAL EXAMINER L. Royer, M.D. Ear 1 **EXAMINER'S** Address (Street, city, town, ar county) moy Ave. Salisbury, Maryland 409 Camden 23d LOCATION (City or Town) (County) (State) 23c. NAME OF CEMETERY OR CREMATORY 23h DATE THEREOF BURIAL, CREMATION Salisbury, Wicomico Memorial Park Maryland BEMOVAL (Specify) Oct. 25,1967 REGISTRAR'S SIGNATURE 2Sq RECD BY REGISTRAR 25b ADDRESS 24. FUNERAL DIRECTOR 1967 VR A15ME (5) HOLLOWAY & COMPANY, SALISBURY, MARYLAND 6M 1/66





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) p. COUNTY o. STATE 5. COUNTY Wicomico Mary land b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY N 16 c CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) puo write RURAL and give nearest town) P.M3 Salisbury Salisbury d NAME OF HOSPITAL OR INSTITUTION (if not in hospito, give street address) d STREET ADDRESS 340 Barclay Street 8. Give Pages Peninsula General Hospital hours ofter death. 3. NAME OF DATE DECEASED DEATH with the within (Type or print) MINNIE LEE along **BROWN** October | 5. SEX 9 AGE (In years 6 COLOR OR RACE 7 MARRIED B. DATE OF BIRTH **NEVER MARRIED** lost bathday) May 4,1894 X Female White WIDOWED DIVORCED 11 BIRTHPLACE (State or foreign country) 100, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUS NESS OR during most of working life, even if retired)
Housewife INDUSTRY Chief Medical Examiner's in any Somerset County, Maryland pencil 14 - MOTHER'S MAIDEN NAME 13 FATHER'S NAME be executed within James Brown/McGrath Martha Elliott 15 WAS DECEASED EVER IN U.S. ARMED EMPLES? 17. INFORMANT 16 SOCIAL SECURITY NO removal. (Yes, no, or unknown) (If yes a ve war or dates at service Mr. Harry H. Sallac (Son-in-law) No College Ave. Salisbury Md. 18. CAUSE OF DEATH (Enter only one couse per lin PART I DEATH WAS CAUSED BY 10 IMMEDIATE CAUSE (o) This certificate should writing the word cremation, Conditions, if ony, which gove use to immediate couse (a), DUE TO stoting the underlying couse burral, PART 1 OTHER SIGN FIGANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) the certificote, its designoted agent, prior to 20o EXTERNAL (AUSE WAS 20b DESCRIBE HOW MULLRY OCCURRED (Enter noture of injury in Port I or Port II of item 18) PRIMARY I or CONTRIBUTING I should CAUSE OF DEATH 20c TIME OF INJURY Month, Day Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home, form (City or town) Hour o.m foctory, street, office bldg. etc.) Not While FUNERAL DIRECTOR: Page ot work of work 21. I certify that I took charge of the remains described above, held an Autopsy [X inspection X Inquiry X 1. death resulted from. Suicide Notural causes Undetermined manner Accident Homicide CHIEF MEDICAL EXAMINER **ACTUAL** ASSISTANT MEDICAL EXAMINER

24 FUNERAL DIRECTOR VR A15ME (ST HOLLOWAY & COMPANY, SALISBURY, MARYLAND

Ear1

409 Camden

23b. DATE THEREOF

L. Royer, M.D.

Ave.

28.1967

SIGNATURE

EXAMINER2

NAME (Type)

23o. BUR AL CREMATION

Burial

REMOVAL (Specify)

moy

50

NAME OF CEMETERY OR CREMATORY

Wicomico Memorial Park

Salisbury,

Salisbury, Maryland

23d. LOCATION (City or Town)

DEPUTY MEDICAL EXAMINER

Address (Street, city lown, or county)

(Stote)

14627

e IS RESIDENCE ON A FARM?

YES NO X

F UNDER 24 HRS

Hours

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19. WAS AUTOPSY

PERFORMED?

and in my opinian

22. DATE SIGNED

1967

NO

(Stote)

NSET AND DEATH

Wicomico

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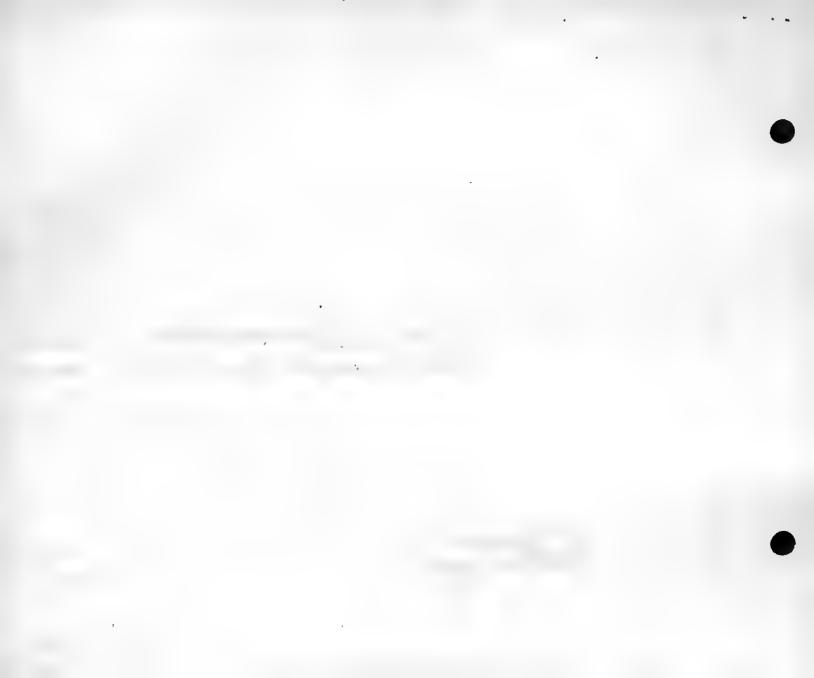
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12 CITIZEN OF WHAT

COUNTRY?

October 27

(County)



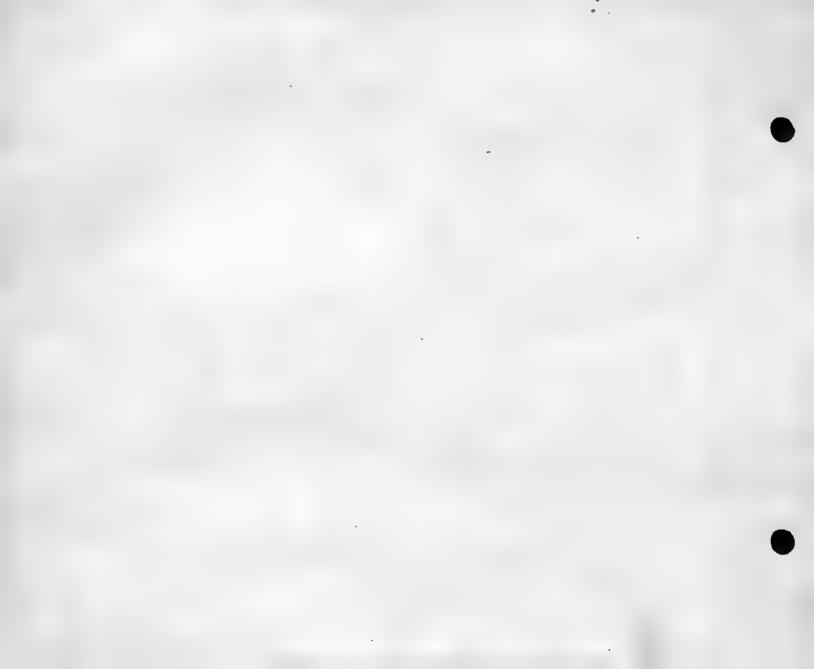
1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201						
		CERTIFICATE CERTIFICATE		DEATH		4628	
Profession of the control of the con	1	PLACE OF DEATH O. COUNTY WICOMICO MARYLAND b. CITY OR TOWN (If ourside corporate imits. C. LENGTH OF STAY IN 16	a.	STATE MAR VLAN	ed lived, if institution: Residence b. COUNTY	CESTER	
24 hours after ed in by the fr pers. Pages 772 hours afte	-	Salisbury d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		SER LI REET ADDRESS	te limits, write RURAL and give	8 IS RESIDENCE ON A FARM?	
		Peninsula General Hospital NAME OF DECEASED (Type of print) SEX 6 COLOR OR RACE 7. MARRIED 12 NEVER MARRIED	3 B	Lòst 4 DATE OF DEATH OF BIRTH	Month ACTUBER AGE (In years IFUNDER)	Doy Year 23 1967 YEAR IF UNDER 24 HRS.	
be executer completes remarkete	100	JSUAL OCCUPATION (G've kind of work done ing most of working life, even if retired) DIVORCED DIVORCED INDUSTRY	00	T, 17, 1894	ost birthday) Months 7 3 yrs reign country) 12. (17)	Doys Hours Min	
h certificate be ng physiciam o Illen please emaval, and in	L	FATHER'S NAME HIRAM POST WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17.	14. N	MOTHER'S MAIDEN NAME	COOKMA	<u> </u>	
squires that the death certificate be executed v physician. signed by the attending physicial all camplete burial-transit permit. Then please remave cart burial, crematian, or remaval, and in any event.		18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (ch) PART I. DEATH WAS CAUSED BY:	Tr.	hromboses	BRUEHL (DE	INTERVAL BETWEEN ONSET AND DEATH	
2000		Conditions, if any, which gove rise to immediate cause (a), stoting the underlying couse lost.	he	resclerons	4		
ATTENDING PHYSICIAN: The low restained by the haspital or attending CTOR: After this certificate has been should be detached for use as the with the State Dept. of Health priar ta	CERTIFICATION	PARE THE OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CASE TO THE SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO 200. ACCIDENT WAS UNDERLYING TO DESCRIBE HOW INJURY OCCURRED.				19 WAS ALTOPSY PERFORMED? YES NO	
NING PHYSICIAL by the haspital fler this certifice be detached fa	MEDICAL CER	OR CONTRIBUTING CICAUSE OF DEATH" (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 20d. INJURY OCCURRED While Not While of work of otwork	CE OF IN	NJURY (Home, form, 20f et, office bldg , etc.)	(City or town) (Cou	nty) (Stote)	
OR ATTENIOR E retained IRECTOR: #		21. I certify that (1) (this haspital) artended the deceased from says the deceased alive on 2.3 19 67, and the 220 SiGNATURE CARLO MAME (Type)	deat AT D. PH	h occurred atA TENDING MED.	o CA Z3, 19 CA, from causes and on the STAFF 22b DA	that (1) (we) last the dote stated obove.	
14	23	BURAL CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR SEMOVAL (Specify) 10 26 67 EVER 6		O 2So. REC'D BY REGISTE	BERLIN YL	(County) (Stote) OR MD	
VR A15 (4) 20 M 1/66		Anna A. Bullage Derlin	10	DATE OF 2 5	1967 RCliany	an Judge	



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. COUNTY o. STATE **b.** COUNTY 2, and 3 ta PM3. Page Wicomico Maryland Worcester \ delay 15 Sydte Department of MARYLAND b. CITY OR TOWN (If outside corporate limits, c TENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury Berlin d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE form ON A FARM? Peninsula General Hospital North Main Street Pages NOX YES This certificate should be executed within 24 hours after death NAME OF Middle 4. DATE First Losi Doy Year DECEASED OF DEATH Burbage Jr. 10-1-67 Give Ernest (Type or print) 19 te certificate, writing the ward "pending" in pencil in Item 18. Giw shauld be forwarded to the Chief Medical ∎xa≡iner's Office along F UNDER 1 YEAR 9 AGE (n years IF UNDER 24 HRS S SEX 6 CO. OR OR RACE NEVER MARRIED 💢 DATE OF BIRTH 7 MARRIED losi birthdoy) Months Doys 910 in any Ivent within 72 haurs after death WIDOWED DIVORCED 10o LSUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR B RTHPLACE (State or fore gn country) 12 CITIZEN OF WHAT during most of working life, even if retired 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME (If yes give wor or dotes of service CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) burial-transit ONSET AND DEATH PART I DEATH WAS CAUSED BY Coronary occlusion Minutes IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse DED lost. be used PART IS OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? cremation, ar remayal, CERTIFICATION the certificate, NO 20b EXTERNAL CAUSE WAS 20b DESCRIBE HOW NURY OCCURRED (Enter noture of injury in Port Lor Port 1 of Item 18) 3 sho≡ld PRIMARY I or CONTRIBUTING I CAUSE OF DEATH 20e, PLACE OF INJURY (Home, form 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (City or fown) (County) (Stote) factory, street, office bldg., etc.) ot work [...] ot work 21 I certify that I took charge of the remains described above, held on Autopsy Inspection X and in my opinian nguiry FUNERAL DIRECTOR: Natural sauses X . Acadent death resulted from Suicide TT. Hamicide I Undetermined manner the funeral director CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER Earl L. Royer EXAMPLER'S M.D. 10-2-67 Tea!th MAINE (Type) Address (Street, city, town, or county) 23d LOCAT ON (City or Town) BURIAL CREMATION (County) (Stote) 5 0 REMOVAL (Specify) 3421 REGISTRAR S SIGNATURE 24. FUNERAL DIRECTOR 250 REC D BY REGISTRAR 2Sb VR A15ME (5) 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14630 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY P COUNTA Wicomico MARYLAND 24 hours after b. CITY OR TOWN (If autside carparate imits, write RURA and give neorest tawn)
Salisbury etelvafilled in by the c. LENGTH OF STAY IN 16 c CITY, OR TOWN (If autside carparate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Peninsula General Hospital YES NO 3 NAME OF DECEASED Middle 4. DATE OF DEATH 1967 (Type or print) PHYSICIAN: The law requires that the death certificate be executed IF UNDER 1 YEAR IF UNDER 24 HRS S SEX DATE OF BIRTH AGE (In years the attending physician and complish sit permit. Then please remove to 6 COLOR OR RACE 7 MARRIED NEVER MARRIED last birthdoy) Days Hours WIDOWED DIVORCED 12 CITIZEN OF WHAT TDa USUA: OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. 8IRTHPLACE (County & State, or foreign country) during most of warking life, even if retired) COUNTRY? INDHISTRY JORCESTE 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, ar inknawn) (If yes give war ar dates of service) KERLIN INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSED BY burnal-transit ONSET AND DEATH signed by IMMEDIATE CAUSE (b) Page 4 may be retained by the hospital or attending physician. DHF TO Canditions, if any, which gave rise to immediate cause (a), DUE TO stoting the underlying cause O FUNERAL DIRECTOR: After this certificate has been use os the PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT BELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO YES detoched for 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 11 of item 18) 2Do ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dd. INJURY OCCURRED 2De, PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg , etc) Hour o.m. Not While at wark should be 21. I certify that (I) (this hospital) attended the deceased from. director, page 3 should should be filed with the saw the deceased alive on 10 - 22 -1962, and that death occurred at $\underline{\mathscr{G}}$ M, from causes and on the date stoted obove. 220. SIGNATURE 22b. DATE SIGNED DIRECTOR M.D. 22c PHYSICIAN 22d. ADDRESS NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION 23b. DATE THEREOF 23d LOCATION (City or Town) (County) (State) SEMOVAL (Specify) EVERGREEN WORCESTER 2Sq. REC'D BY REGISTRAR



VR A15 (4) 25M 1/67

24. FUNERAL DIRECTOR 250 REC'D BY REGISTRAR

CHESAPEAKECITY CELIL

NO

NO X

(Store)

(State)



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14632 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Salisbury The law requires that the death certificate be executed within 24 hou d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS Peninsula General Hospital YES IN NO Middle NAME OF Lost physician and completely OF DEATH DECEASED (Type or print) please remove cor F UNDER I YEAR SFX 6 COLOR OR RACE DATE OF RIRTH AGE (In years 7. MARRIED NEVER MARRIED buthday) Months Hours WIDOWED DIVORCED and in ony 12 CITIZEN OF WHAT 10b. KIND OF BUSINESS OR **COUNTRY 7** during most of working life, even if refired) INDUSTRY 13 FATHER S NAMI or removal, 17. INFORMANT Address IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service) cremation, 18 CAUSE OF DEATH (Enter only one couse per lipe for (o), buriol-transit p PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO signed 1 Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse Poge 4 may be retoined by the hospital or attending os the priar to O FUNERAL DIRECTOR: After this certificate hos been last WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) USe NO [ģ 205 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20° ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., (fc.) Not While of work a) work 21. I certify that (I) (this haspital) attended the deceased fram. and that death occurred at 5 M from causes and an the date stated above saw the deceased alive and 22b. DATE SIGNED 22o. SIGNATURE DIRECTOR PHYS M.D PHYS 22d ADDRESS 22c PHYSICIAN'S NAME (Type) director, should b 23¢ NAME OF CEMETERY OR CREMATORY 23d LOCATIONLICity or Town (Stote) 23b DATE THEREOF 23o. BURIAL CREMATION. REMOVAL (Specify) / 2Sb. REGISTRAR'S SIGNATURE 2So, REC'D BY REGISTRAR VR A15 (4) DATE OCT 24 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14633CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH etak filled in by the funerol orban popers. Pages Land p. COUNTY o. STATE b. COUNTY Wicomico Wicomico MARYLAND Marvland b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) write RURAL and give nearest town) Salisbury Salisbury mons. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e. 15 RESIDENO ON A FARM? NO Fer Wicomico Nursina Spring YES Home 4. DATE NAME OF Middle Month First Lost Doy Year DECEASED (Type or print) 4 CHURCH DEATH October please remove co FUNDER I YEAR IF JNDER 24 HRS physician and compl AGE (In years \$ SEX 8 DATE OF BIRTH 6. COLOR OR RACE 7 MARRIED NEVER MARRIED lost birthdoy) Months Doys Hours WIDOWED DIVORCED Male White Jan. 10o. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working ife, even if retired) INDUSTRY England

14. MOTHERS MAIDEN NAME Minister Ret. Baptist Unknown 13. FATHER'S NAME removol, signed by the offending phy buriol-transit permit Then Unknown Unknown 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) ((If yes give wor or dates of service) 6 H177 M 2111-211-2665[W1771am.A. Harris Snow buriol, cremation, 18 CAUSE OF DEATH (Enter only one couse per une for (o), (b), ONSET AND DEATH PART L DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Poge 4 may be retained by the haspital ar ottending physician. DUE TO Conditions, if any, which gove rise to immediate couse (o), DUE TO stating the underlying couse be detached for use os the State Dept. of Heolth priar ta has been last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION NO YES O FUNERAL DIRECTOR: After this certificate ATTENDING PHYSICIAN: 20o. ACCIDENT WAS UNDERLYING 20b, DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Part 1 or Port II of item 18.) OR CONTRIBUTING (CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) 20c TIME OF INJURY Month, Day, Year (Stote) Hour a.m. foctory, street, office bldg., etc.) Not While ot work ot work 21. I certify that (1) (this haspital) attended the deceased from 7.1 director, page 3 should should be filed with the and that death occurred at M, from couses and on the date stated above. sow the deceased alive on. 22o. SIGNATURE 22b. DATE SIGNED STAFF PHYS. ATTENDING DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) William Smith Salishury MI 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230 BURIAL CREMATION. 23b. DATE THEREOF (County) (Stote) PEMOVAL (Specify) 10/71967 Spence Bantist Snow Hill 25b. REGISTRAR'S SIGNATURE 2So REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) DATOCT 9 1967 Snow Hill, Md. 20 M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14634 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death. 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH o. COUNTY o. STATE **b** COUNTY Wicomico MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sallsbury c LENGTH OF STAY IN 16 c CITY OR TOWAY (If outside corporate limits, write RURAL and give nearest town) filled in d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENC Opene ON A FARM? Peninsula General Hospital NO TX YES [NAME OF 4. DATE Month Year the attending physician was carban to a sample carban blease remays carban to a sample and the sample are sam First Lost Dov DECEASED DEATH (Type or print) AGE (In years IF UNDER 1 YEAR IF LINDER 24 HRS 6. COLOR OR RACE 7 MARRIED NEVER MARRIED birthdoy) Doys Hours DIVORCED WIDOWED TOO JSUAL OCCUPAT ON (Give kind of work done 10b. KIND OF BUSINESS OR (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if replied) INDUSTRY 14 MOTHER S/MAIDEN NAME 13. FATHER'S NAME 16. SOCIAL SECURITY NO INFORMAN 15 WAS DECEASED EVER IN U.S. ARMED FORCES? Address (Yes, no, or unknown) (If yes give wor or dotes of service) 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN burial-transit ONSET AND DEATH PART 1 DEATH WAS CAUSED BY 8/0 IMMEDIATE CAUSE (o) signed by by the haspital ar attending physician. DUE TO Conditions, if any, which gove nse to immediate couse (a), DUE TO stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been far use as the 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO S 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.) 20o ACCIDENT WAS JNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. Not While factory, street, office bldg, etc.) shauld be 21. I certify that (I) (this h 1967 , 196), that (I) (m) last attended the deceased fram_ be retained and that death occurred of M. from couses and an the date stated above. sow the deceased olive on 220 SIGNATUR 22b. DATE SIGNED **ATTENDING** 16 directar, page 3 shauld be filed v M.D. DIRECTOR ADDRESS 22c. PHYSICIAN'S Pine NAME (Type) NAME OF CEMETERY OR CREMATORY 23b. DAJE THEREOI LOCATION (City or Fown) 23o. BURIAL CREMATION. fitote) REMOVAL (Specify) ADDRESS 256 REGISTRAR'S SIGNATURI 24. FUNERAL DIRECTOR YR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH





14628

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs

Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14636

PLACE OF DEA	Н		2. USUAL RESIDE o. STATE	NCE (Where deceased lived, if institution b. COI		before odmission)
	icemice	MARYLA		aryl and		bot
b CITY OR TOV	N (f outside corporate limits, and give nearest town)	c LENGTH OF STAY IN	Ib CITY OR TOWN	(If outside corporate limits, write R	URAL and give no	eorest town)
S	al isbury_	1 mo. h da	vs Easton			
d NAME OF HO	SPITAL OR INSTITUTION (If not	in hospitol, give street oddress)	d. STREET ADDRE	SS		e IS RESIDENCE ON A FARM?
Deer 1	Head State	ospital	Rt. #2	(Black Dog Alley	r.)	YES NO
3. NAME OF	First	Middle	Lost	4. DATE Mo		Doy Year
(Type or print)	Arthur	Elliott	Cook	DEATH Octobe	27	29 19 6
S. SEX	6. COLOR OR RACE	7 MARRIED NEVER MARRIED	B DATE OF BIRTH	9 AGE (In years last birthday)	F UNDER 1 YI	EAR IF UNDER 24 H
Mala	White	WIDOWED DIVORCED	□ 7/4/1901	66 Yrs	monins D	oys nous in
10o USUAL OCCUPA	ON (Give kind of work done	IDE KIND OF BUSINESS OR	11 BIRTHPLACE (C	ounty & State, or foreign country)	12 CITIZE	EN OF WHAT
duting thost of Mot	ing life, even if retired)	INDUSTRY	Queen .	Anne, Maryland	COUN	SA
13. FATHER S NAA	E		14. MOTHER'S MA			- 8.0
Joseph	Cook		Mamie	Elloitt		
	EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO.	17. INFORMANT		ress	
(Yes, no, or unknot	(If yes give war or dates of :	P20-32-1421	Mrs. Sarah	Marie Cook, RFI	#2 Fo	aton III
I IR CAUSE O	F DEATH (Enter only one couse	per line for (o), (b) and (c))	Jan Co Dazan	med re goon, the	اعتر و ۱۳۳۵	INTERVAL BETWEET
PART I.	DEATH WAS CAUSED BY.	Lino-Sarcome	eff Chest w	ith Extensive		ONSET AND DEATH
1971	IMMEDIATE CAUSE (o DUE TO	Dad man and Make				1 yr.
Conditions, if	ony, which gove) (b	•				- J1.
nse to imme	diate couse (o), (
lost.	nderlying couse (
PART II. OTH		TRIBUTING TO DEATH BUT NOT RELAT	ED TO THE TERMINAL DISEA	SE CONDITION GIVEN IN PART I(o)		19 WAS AUTOPSY
TION						PERFORMED?
200 ACCIDENT OR CONTRIBUTION OR CONTRIBUTION OR CONTRIBUTION OR CONTRIBUTION OF CONTRIBUTION O	WAS UNDERLYING	20b DESCRIBE HOW INJURY OCCU	JRRED (Enter noture of inju	ury in Port I or Port II of item 18.)		
OR CONTRIBU	ING CAUSE OF DEATH		,			
3 20r. TIME OF	INJURY Month, Doy, Yeor	20d INJURY OCCURRED 2	De. PLACE OF INJURY (Home	e, form 20f (Crty or town)	(Count	y) (Stote
20c. TIME OF	0.m.	While Not While	foctory, street, office bld		•	
21 1 4	p.114.	tal) attended the deceased from	m Sentember	250 67 to Dot 2	0 10 67	7 that (1) (wa)
saw th	deceased alive as O	ct. 29. 19 <u>67,</u> an	d that death accurre	d of 7 Of M from rouses	and on the	date stated ah
220 SIGNAT					22b DATE	
	tterne	LICENIT	M.D PHYS	DIRECTOR PHYS	2 10v	100/00
22c. PHYSICI			22d ADDRESS			29/67
NAME (1	Abe) C. H. MTIMIN	ACOTT, M.D.	Deer	s Head State Hos	pital,	alisbury
230 BURIAL, CREA	ATION. 23b DATE THER	EOF 23c NAME OF CEMETE	RY OR CREMATORY	23d. LOCATION (City or 1	own) ((c	ounty) (Stote)
Burial (Sp						.,
24 FUNERAL DIR	CTOR .	ADDRESS	250	REC D BY REGISTRAR 1 25b	REG STRAR'S SIGN	
	D. HEUER	a) To anton	Mid.	NOV 1 1967 /	thank	, lucker



MARYLAND STATE DEPARTMENT OF HEALTH - Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requims that the deoth certificate by executed within 24 hours after death by the funerol Poges I and 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. COUNTY **b** COUNTY Wicomico oges 1 ofter MARYLAND b CITY OR TOWN (If autside carporate armits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate amits, write RURAL and give nearest town) Salisbury SHARPTOWN Filled in poper thin 22 h e IS RESIDENC d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM Peninsula General Hospital NO E YES NAME OF Middle DATE First Day Year corbor physician and completely DECEASED OF DEATH (Type or print) 🖊 F UNDER 1 YEAR 9. AGE (In years NEVER MARRIED DATE OF BIRTH 7 MARRIED remove birthday) Months Days Hours and in ony DIVORCED 10b KIND OF BUSINESS OR THPLACE (County & State or foreign country) 12 CITIZEN OF WHAT doring most of working life, even if retired) COUNTRY? INDUSTRY pleose USSEX U PON! ATTO FATHER S NAME 14 MOTHER'S MAIDEN NAME or removal. еп signed by the attending burial-tronsit permit. Th WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, na, or unknown) (If yes give war at dates af service No cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEATH PART 1 DEATH WAS CAUSED BY-IMMEDIATE CAUSE (a) ottending physicion. DUE TO burial, Canditians, if any, which gave rise to immediate cause (a), DUE TO prior to stoting the underlying couse the hos been last. GS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART ICO WAS AUTOPSY PERFORMED? CERTIF CATION NO be retained by the hospitol or O FUNIRAL DIRECTOR: After this certificate jo 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, form, 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20f (City or town) (County) (Stote) factory, street, affice bldg., etc.) Hour a.m. While Nat While Stote at work L at wark 21. I certify that (I) (this haspital) attended the deceased fram. should saw the deceased alive an 1967 and that death accurred at 5 k. M. fram causes and an the date stated above r, page 3 shou be filed with t 220 SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR PHYS. PHYS. 22c. PHYSICIAN'S 22d **ADDRESS** NAME (Type) director, should 234 LOCATION (City or Town) NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION 23c (County) (State) REMOVAL (Specify) 1A 25o. REC'D BY REGISTRAR ADDRESS FUNERAL DIRECTOR VR A15 (4) 20 M 1/66





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14639 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH b. COUNTY Worcester o. COUNTY o. STATE delay is and 3 to Maryland PM3. Poge Wicomico MARYLAND 6 CITY OR TOWN (If autside carparate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If auts de carparate imits, write RURAL and give nearest tawn) write RURAL and give nearest tawn) 13 days Salisbury Bishopville Depor d NAME OF HOSP TAL OR INSTITUTION (If not in haspital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS in pencil in Item 18. Give Pages 1, 2 Examiner's Office along with forms Peninsula General Hospital YES NO This certificate should be executed within 24 hours ofter death please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pagadirector. Page 4 should be forwarded to the Chief Medical Examiner's Office along with 3 NAME OF Frst Middle 4 DATE Month buriol-tronsit permit. File pages I ond 2 with the St Lost Day Year DECEASED OF DEATH Granville 10-29-67 Cropper (Type or print) NEVER MARRIED 7 8 DATE OF BIRTH F UNDER 1 YEAR IF UNDER 24 HRS. 5 SEX 6 COLOR OR RACE 9 AGE (n years 7 MARRIED last birthday) Months Davs Haurs in ony event within 72 hours after deoth WIDOWED DIVORCED 10-9-71 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or fareign country) 12 CIT ZEN OF WHAT during most of working life, even if retired)
Retired Fostmaster INDUSTRY S. COUNTRYSA Mail Maryl nd 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Charles W. Crorpar Ann Kathryn Grav IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECTIBITY NO 17 INFORMANT Address (Yes, no, or unknown) If If yes give wor or dates at service 214-34-3238 Dulla Cropper i . opvill. XX 18. CAUSE OF DEATH (Enter only one cause per line far (a) (b) and (c).) INTERVAL BETWEEN ONE T AND DEATH PART I DEATH WAS CAUSED BY HMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise ta immediate cause (a). DUE TO stating the underlying couse cremation, or removal, and be used 19 WAS AUTOPS)
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT DOT BETATED TO THE TERM NAL DISEASE COND T ON GIVEN N PART 1(a) CERTIFICATION NO 20a EXTERNAL CAUSE WAS PRIMARY I or CONTRIBUTING 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I at Part II af Item 18.) 3 should CAUSE OF DEATH Fell at own home. MEDICAL 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20f (City or tawn) 20c TIME OF INJURY Month, Day, Year (State) Not While factory, street affice bldg, etc.) at wark 10-16-67 at wark Bishopville Worcester Md. Own home. 21. I certify that I tack charge of the remains described above, held an Autapsy [7], Inspection X. Inquiry 🔀 and in my apinian death resulted from: Natural causes A. Accident X Suicide 🗌 Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER Earl L. Royer, M.DO 10-30-67 Health | Address (Street city town, or county) 23a BURIAL, CREMATION 250 DATE THEREOFE Salisbury 23d LOCAT ON (City or Town) (County) 0 REMOVAL (Specify) . . 1 S DOVI lie, Md. 25b. REGISTRAR S SIGNATURE 24. FUNERAL DIRECTOR 26a. REC'D BY REGISTRAR VR A15ME (5) 1961

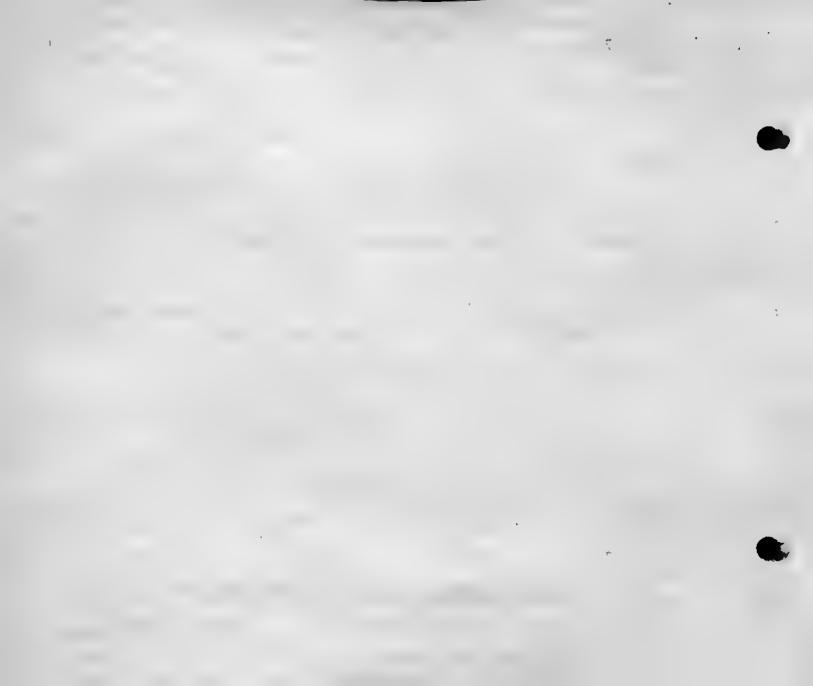


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12630 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death and cample en Atted in by the funeral remove carbon papers Pages I and PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Wicomico o. COUNTY o. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS Peninsula General Hospital NO w M DATE NAME OF Middle First Lost Year DECEASED OF DEATH 0 19 (Type or print) S SEX 8 DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS COLOR OR RACE 7 MARRIED **NEVER MARRIED** birthdoy) Months Dovs Hours WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired INDUSTRY COUNTRY? townswor 13 FATHERS NAME 14 MOTHER'S MAIDEN NAME or remayal, the attending 16. SOCIAL SECURITY NO WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address permit. (Yes, no or unknown) (If yes give wor or dates of service) INTERVAL BETWEE 1B CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY: ABDIAC ABOYTH. IMMEDIATE CAUSE (o) Ingned by DUE TO Conditions, if any, which gave SCV DISEASE NDEF nse to immediate couse (a). DUE TO stoting the underlying couse by the haspital or attending as biin as the last. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? od far use af Health p OLEDOCHOLETHIASIS NO **INNERAL DIRECTOR:** After this certificate YES 205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, form, (City or town) (Stote) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (County) Not While foctory, street, office bldg, etc.) ot work 196 7 196 7, that (1) (yet) last 21. I certify that (I) (this hospital) attended the deceased fram_ shauld SM, fram causes and an the date stated above 19 6 7 and that death accurred at ... saw the deceased alive an 22b. DATE SIGNED 22o. SIGNATURE ATTENDING M.D. DIRECTOR PHYS page 3 22d ADDRESS PHYSICIAN S NAME (Type) MEDICAL SALISBUMY BLOXOM director, particular de CENT. BURIAL, CREMATION DATE THEREOF 23c NAME OF CEMPTERY OR CREMATORY 23d LOCATION (City or Town) (Stote) **FUNERAL_DIRECTOR** REC D BY REGISTRAR **VR A15** 20 M 1/86



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. STATE **b.** COUNTY o. COUNTY Wicomico Wicomico MARYLAND Maryland The law requires that the death certificate be executed within-24-hours after c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 15 b CITY OR TOWN (If outside carparate simits, Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENC ON A FARM? Peninsula General Hospital 403 Mount Street NO X YES 🖂 within Middle 4. DATE Year 3 NAME OF First Lost Month Day the attending physician and completely (sit permit. Then please remove carbon DECEASED CLEVELAND (Type or print) DEATH nnis DATE OF BIRTH S SEX (In years 6 COLOR OR RACE 7. MARRIED NEVER MARRIED last birthdoy) 82 yrs. Manths Days Hours Sept. 25,1885 DIVORCED and in ony Male White WIDOWED 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT 10a, USUA, OCCUPATION (Give kind of work done during most of working ite, even if retired)
Retired Farmer Farming COUNTRY? Worcester County, Md. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Purnell J. Dennis Alice Hudson INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. buriol-transit permit. Mrs. Alice K. Brittingham (Daughter) 7-54-5343 403 Mount Street, Salisbury, Maryland NTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per Interfor (9), (b), and (c).) ONSEL AND DEATH PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stoting the underlying cause be retoined by the hospital or attending O FUNERAL DIRECTOR: After this certificate has been os the PART HE OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO 205. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Part I or Part II of Item 18.) 200 ACC DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (City or fown) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) 15, 1962 that (1) (we) last 19 6 21. I certify that (I) (this haspital) attended the deceased fram_ A. M, fram causes and an the date stated above. saw the deceased alive an I let 15 7967, and that death accurred at 2 22b DATE SIGNED 220. SIGNATURE Oct. 16, 1967 M.D. DIRECTOR PHYS director, poge 3 should be filed v 22d. ADDRESS 22c PHYSICIAN S Medical Center, Salisbury, Maryland NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (Stote) 23a. BURIAL CREMATION, B REMOVAL (Specify) 18, 1967 Wicomico Memorial Park Salisbury, Maryland 25b. REGISTRAR'S SIGNATURE 2Sq. REC'D BY REGISTRAR ADDRESS 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 HOLLOWAY & COMPANY, SALISBURY, MARYLAND

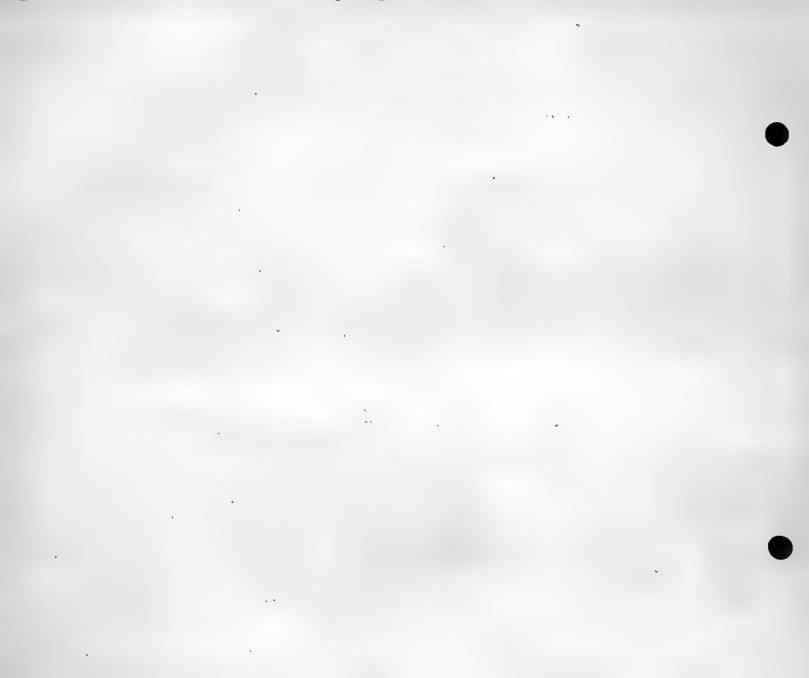




Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14032 14643 CERTIFICATE OF DEATH Beer 2 24 hours after death. signed by the ottending physicion ond completery tilled in by the funeral buriol-transit permit. Then please remove carbon popers. Poges I and buriol, cremotion, or removol, and in any event, within 72 hours after details. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY Wicomico MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RLMAR - Rural Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? Near Columbia YES K NO Peninsula General Hospital requires that the death certificate be executed within 3. NAME OF 4. DATE Lost October DECEASED AIRES XXXXXXXXXXXXX (Type or print) DEATH S. SEX 6 COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER 24 HRS **NEVER MARRIED** lost birthdoy) Doys Hours WIDOWED DIVORCED 11. BIRTHPLACE (County & State, or foreign country) 10a USUAL OCCUPATION (Give kind of work done K ND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life even if retired)
Housework COUNTRY? Delmar, Delaware 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME James Games Easter Games 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT (Yes, no, artinknown) (If yes give wor or dates of service Unknown Russell Gaines, Delmar, Del., RFD #2 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) physician. DUE TO euro sclerosis Conditions, if ony, which gove rise to immediate cause (a), DUE TO stoting the underlying couse Page 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been os the prior to lost. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO TA lerosis ģ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) 200 ACCIDENT WAS UNDERLYING [1] OR CONTRIBUTING CAUSE OF DEATH be detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (Stote) 20c TIME OF INJURY Month, Doy, Year (City or fown) (County) Hour p.m. factory, street, office bldg., etc.) 19 67, that (I) (100) last 2]. I certify that (I) (this hospital) attended the deceased from OCY should 1967 , and that death accurred at 135 M, fram causes and an the date stated above. saw the deceased alive an 220. SIGNATURE 22b. DATE SIGNED STAFF PHYS. ATTENDING M.D. DIRECTOR Aura director, page should be filed 22d_ ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMAT ON 23b DATE THEREOF Nov.2.1967 Mt. Nebo Cemeterv Near Delmar Delaware
REGISTRAR 25b REGISTRAR'S 5 GNATURE 24. FUNERAL DIRECTOR once Translow 2So. REC'D BY REGISTRAR VR A15 (4) 1967 Framptom and Son, Federalsburg, Md. 20 M 1/66



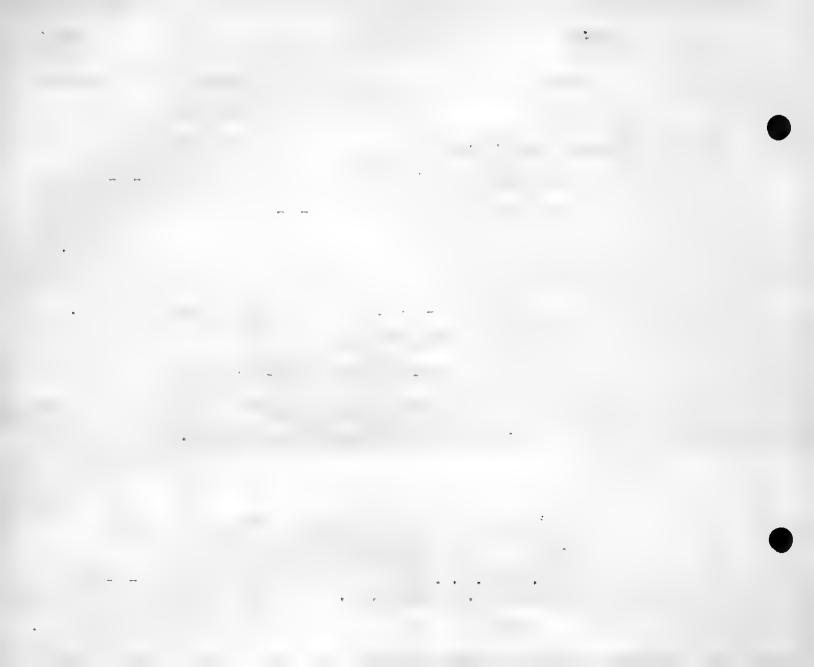
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS. 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY Pages 1 : COMICO Worke MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 1b f outside corporate limits, write RURAL end give nearest town) write RURAL and give nearest town) hours hours Nest. 5 lis e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS on paper ON A FARM? 24 No 3 YES death certificate be executed within 3. NAME DE Middle DATE DECEASED DF (Type or print) P+1 DEATH 19 6 10 e remove i AGE (In years | IFUNDER 1 YEAR | IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE DATE OF BIRTH 9. 7887 7. MARRIED NEVER MARRIED Months NOV. WIDOWED K DIVORCED physician and ph 12. CITIZEN OF WHAT COUNTRY? 10a. USUAL OCCUPATION (Give kind of work done I 10b. KIND OF BUSINESS OR 11. BIRT HPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY ock Tox attending phys ermit. Then ple n. or removal, a 13. FATHER'S NAME MDTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address 17. been signed by the atten the burial-transit permit. or to burial, cremation, or MARKE (Yes, no, or unknwn) (If yes give war or dates of service) CAUSE OF DEATH [Enter only one cause per line for PART I. DEATH WAS CAUSED BY the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions. If onv. which gave rise to immediate **DUE TO** cause (a), stating the as th underlying cause last. (c) CERTIFICATION PART M. OTHER SIGNAFICANT CONDITIONS CONTRIBUTING TO DEATH BUT OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART A(a) 19. WAS AUTOPSY for use Health p PERFORMED? NO YES [DESCRIBE HOW INJURY OCCURRED. (Enter nature of Infery in Part I or Part II of Item 18.) Ma. ACCIDENT WAS UNDERLYING THE CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detached for the Dept. of I MEDICAL TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour Not While at work OR ATTENDING be retained by at work D certify that (I) (this hostital) attended the deceased from DIRECTOR: age 3 should led with the M. from the causes and on the date stated above. saw the deceased alive on and that death occurred 22b. page MED. DIRECTOR STAFF PHYS. M.D. Page 4 may O HOSPITAL ADDRESS FUNERAL HYSICIAN'S 22d, director, p NAME (Type) BURIAL, CREMATION, DEMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town or county) (State) 23a. BURIA NOW 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR AI5 (4)



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH hoùrs after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) o. COUNTY o STATE **b** COUNTY Wicomico MARYLAND b CITY OR TOWN (If autside carparate limits, c LENGTH OF STAY IN 1h c. CITY OR TOWN (If auts de carporate limits, write RURAL and give nearest tawn) RURAL-and give pearest town) d NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d STREET ADDRESS e IS RES DEN ON A FARM Peninsula General Hospital YES NO NAME OF DECEASED Middle DATE Last First Manth Dov corban GREEN (Type or print) DEATH ctober requires that the death certificate be executed DATE OF BIRTH S SEX IF UNDER I YEAR IF UNDER 24 HR AGE (in years 6 COLOR OR RACE 7 MARRIED NEVER MARRIED please remave birthday Months WIDOWED DIVORCED 10a LSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT INDUSTRY COUNTRY? 40m 13. FATHER SANAME 14. MOTHER'S MAIDEN NAME IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service INFORMANT 18. CAUSE OF DEATH (Enter only one cause per life PART I. DEATH WAS CAUSED BY. burial-transit IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gave (b) rise to immediate cause (a), DUE TO stoting the underlying couse as the TO FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING NO DEATH BUT NO RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART. OSe be retained by the haspital ar 0 205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 of Part II of Item 18.) 20g ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f (City or town) (County) (State) Not While factory, street, affice blda., etc.) 2). I certify that (I) (this hospital) attended the deceased from M, fram causes and an the date stated above and that death accurred at saw the deceased alive an 22a SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. STAFF PHYS DIRECTOR ADDRESS 22c. PHYSICIAN'S NAME (Type) 23a BURIAL, CREMATION, 23b. DATE THEREOE OF CEMETERY OR CREMATORY 23d, LOCATION (City or Town) (County) VR A15 (4) 20 M 1/66 DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14646 HEALTH DEP PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission). p COUNTY o STATE b. COUNTY delay is ond 3 to M3 Poge Maryland Wicomico Somerset MARYLAND b (ITY OR TOWN (If outside corporate limits, write RURAL and give necrest town)
Salisbury c (ITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 1h 2, ond PM3 F Princess Anne d STREET ADDRESS S RESIDENCE ON A FARM? d NAME OF HOSP TAL OR INSTITUTION (i not in hosp to, q ve street address) word "pending" in penal in Item 18. Give Poges 1, the Chief Medical Exominer's Office along with form Route # 3 Box 322 Peninsula General Hospital YES NO F This certificate should be executed with n 24 hours ofter death he Stat 3 NAME OF 4 DATE First Midd e Lost Month Doy Year DECEASED OF 10-25-67 Edna Louise Hall (Type or pant) DEATH 19 guojo 5 SEX 9 AGE (n years F UNDER 1 YEAR 6 COLOR OR RACE B DATE OF BIRTH 7 MARRIED X. NEVER MARRIED lost buthday) Months Davs Hours 2-19-12 hours ofter death WIDOWED DIVORCED Office o 1 BIRTHPLACE (State or foreign country) 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY Domestie
13 FATHER'S NAME Maryland
14 MOTHER'S MAIDEN NAME ILS.A nallace white Emma woolford 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no. or unknown) (If yes give wor or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address within 191-38-0109 Oliver Hell Princess Anne Md. 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSEL AND DEATH event PART I, DEATH WAS CAUSED BY. Congestive heart failure IMMEDIATE CAUSE (o) certificate, writing the word DUE TO Conditions, if ony, which gove Hypertensive cardiovascular disease Years (b) rise to immediate couse (a), forworded to DUE TO stating the underlying couse Stricture of the abdominal acrta Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) removal, 19 WAS AUTOPSY PERFORMED? YES X NO. Patient expired under anesthesia for aortic bypass. e q 20a EXTERNAL CAUSE WAS PRIMARY ☐ OF CONTRIBUTING ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18.) MEDICAL EXAMINER: CAUSE OF DEATH 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form 20f (City or town) (County) 20c. TIME OF INJURY Month, Day, Year Not While factory, street, office bldg, etc.) DIRECTOR: Page of work L of work 21. I certify that I took charge of the remains described above, he d on Autopsy XI. Inspection XI. Inquiry X and in my apintan 5 Natural causes ... Surcide 1. death resulted from Accident . Ham cide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE funeral DEPUTY MEDICAL EXAMINER 10-27-67 Earl L. Royer. M.D. Address (Street, city, town, or county) NAME (Type) 230 BUR A' CREMATION the 23d LOCATION (City or Town) (County) REMOVAL (Specify)
Burial Church 250 RECD BY REGISTRAR 24 FUNERAL DIRECTOR VR A15ME (5) 5 DATE NOV 3 6M 1/67





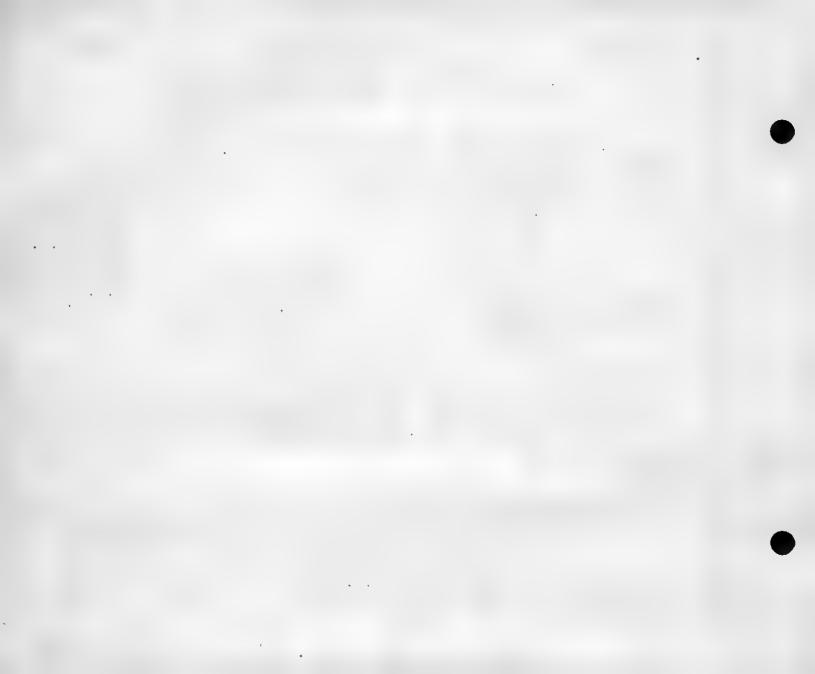


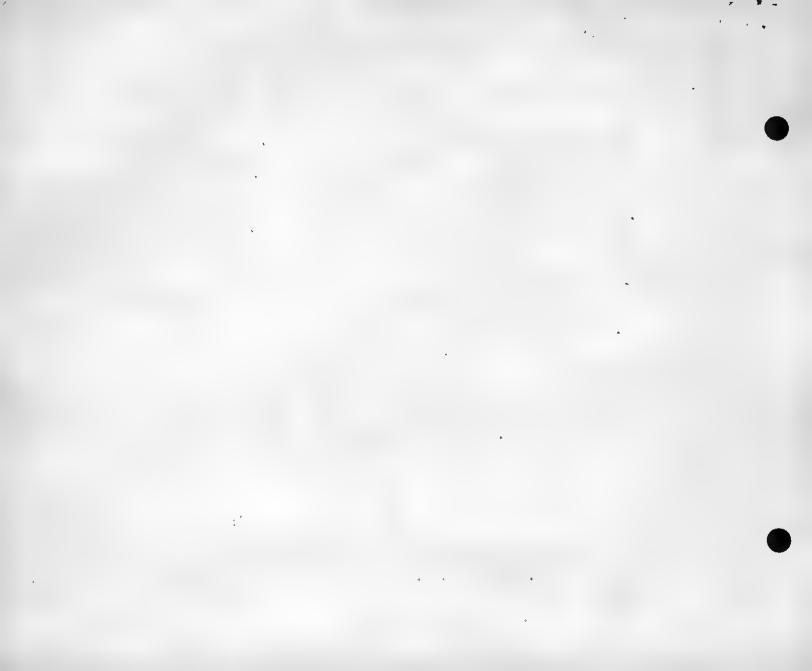
	MARYLAND 21201 14649
1 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, is	f institut on Residence before admission)
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The Children's Invalid	
Pemberton Hickman Anna Bunting 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT	Address
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18. CAUSE OF DEATH (Enter on y one course per line for (a), (b), and (c))	INTERVAL BETWEEN
PART I, DEATH WAS CAUSED BY.	ONSET AND DEATH
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(Conditions, if any, which gove) (b) Corllagen Vascular Dissert	
nse to immediate cause (a), Stoting the underlying cause DUE TO	
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OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
200 ACCIDENT WAS UNDERLYING 200 ACCIDENT WAS	town) (County) (State)
p.m. 17 at work C at work C	
21. I certify that (I) (this hospital) attended the deceased from 10 1962, to 10 saw the deceased olive on 1962, and that death occurred at 127, M, fram	salves and an the data stated above
sow the deceased olive on 10 1967, and that death occurred at 1277, M, fram 22a. SIGNATURE	22b. DATE SIGNED
1 770 MINRIUKE	AFF 0 11-3-67
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M.D. PHYS. DIRECTOR PH	
M.D. PHYS. DIRECTOR PH	
M.D. ATTENDING M.D. PHYS. 22c. PHYSICIAN'S NAME (Type) 23g. BURIAL, GREMAT ON, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (4)	City ar Town) (County) (State)
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22c. Physician's NAME (Type) 23g BURIAL, CREMATON, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (4)	256 REGISTERR'S STEEL TURE



1 5	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201							
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OR ATT OR ATT OF retail OR ATT OR ATT OR ATT OR WITH		Thomas C. Hill Jr., M.O. ATTENDING DIRECTOR DISTAFF DI 10	TE SIGNED - 17-67					
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TO HOSPI) Page 4 m TO FUNER director, should b	1/2	REMOVAL (Specify) 10.20 67 EleNHAVENMEATICEM Glen Burnie	County) (Stote)					
VR A15 (4) 20 M 1/66	2	Thomas I Carry he books to line 250. RECD BY REGISTRAR 2510	GNATURE					







MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON, STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) WKONICO o. STATE b. COUNTY Wilomico MARYLAND hours after b CITY OR TOWN (If outside carporate limits, c LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) ON A FARM? PHYSICIAN: The law requires that the death certificate be executed within 24 filled Purnell Street YES FT-NO NAME OF Middle First DATE Year DECEASED (Type or print) DEATH S SEX AGF (In years IF UNDER 1 YEAR **NEVER MARRIED** lost birthdoy) Months Hours and in any WIDOWED DIVORCED -3-1883 12 CIT ZEN OF WHAT 1Do JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR physician nen pleas during most of working life, even if retired) 13. FATHER'S NAME ar remaval, 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) burial, crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate cause (a), DUE TO stoting the underlying couse this certificate has been WAS AJTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) YES NO 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 2De PLACE OF INJURY (Hame, farm, (City or fawn) (County) (State) 20c TIME OF INJURY Month, Doy, Year factory, street, office bldg , etc) Not While of work 21 I certify that (I) (this haspital) attended the deceased from Z (*) be retained and that death occurred at -00 an the date stated above FUNERAL DIRECTOR: saw the deceased alive an_ M, fram couses and 220 SIGNATURE 22b. DATE SIGNED **ATTENDING** M.D. PHYS. DIRECTOR PHYS. 22d. ADDRESS PHYSICIAN'S NAME (Type) director, should be 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, SALS BURY 10,00 -25o. REC'D BY REGISTRAN



1.1/	MARYLAND STATE D	EPARTMENT OF HEALTH 01 W. PRESTON STREET, BALTIMORE, MARYLAND	21201
W.	Division of STATISTICAL RESEARCH AND RECORDS, 30 Item #8 Film #G391 TERTIFICAT	E OF DEATH	13142
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in 24 ho filled in popers, hin 72 b	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) Peninsula General Hospital	d. STREET ADDRESS	B. IS RESIDENCE ON A FARM? YES NO
	3 NAME OF DECEASED (Type or print) ANNA E. Middle	JONES 4 DATE OCTOBER	30 1967
execute nd camp emove any eve	S SEX 6 CÓLOR OR RÀCE 7 MARRIED NEVER MARRIED DIVORCED 100 USUAL OCCUPATION (G ve kind of work dane 10b. KIND OF BUSINESS OR	17-10-1/8/96 last birthday) Mar	INDER I YEAR IF UNDER 24 HRS Onths Doys Hours Min. 12. CITIZEN OF WHAT
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e death attendi permit.	(Yes, no or unknown) (If yes give war ar dates of service) 226-01-2458 A	NNA MAE GALE Rt	PRINCESS ANNE
equires that the death ce physician. signed by the attending burial-transit permit. Th burial, crematian, ar rem	18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO	al Infarction	ONSEI AND DENTI
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ATTEN etained CTOR: A shauld vith the	saw the deceased alive on 19 (2) 19 (2) and the	at death accurred at 12 3M, fram causes and	an the date stated above. 2b. DATE SIGNED
TAL OR noy be r AL DIRE page 3	22c. PHYSICIAN'S NAME(Type)	A D PHYS DIRECTOR PHYS DI	
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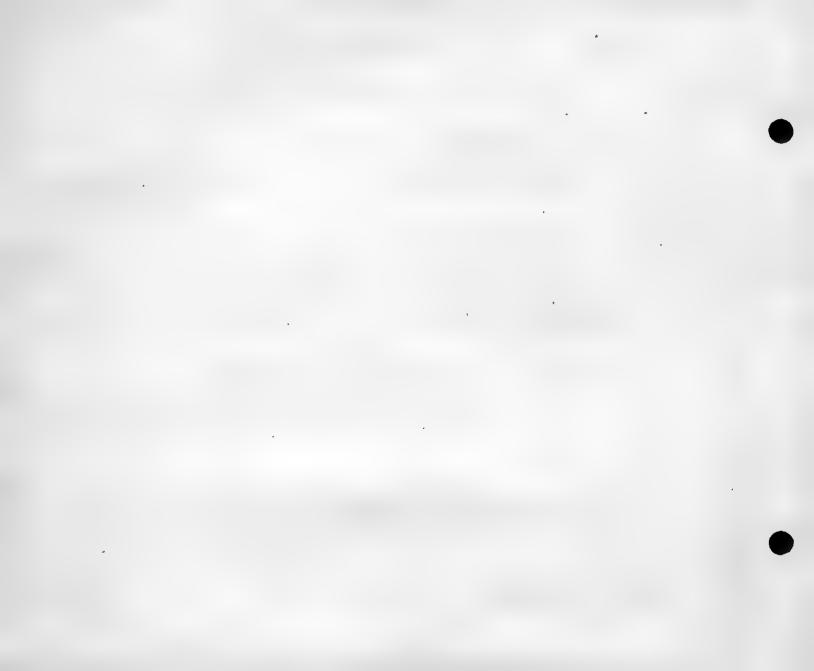


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2120J 1 LF 45 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 1. PLACE OF DEATH o. STATE Maryland & COUNTY icomice a COLINTY Wicomico MARYLAND b City OR TOWN (If outside corporate smits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-and give give nearest town) Salidbury d STREET ADDRESS e. IS RESIDENCE ON A FARMS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) filledan Peninsula General Hospital 318 Cherryway YES 🗍 NO A NAME OF DECEASED Middle DATE Year First Manth Paul Scott 196 DEATH (Type or pont) IF UNDER 24 HRS S SEX 6. COLOR OR RACE 7. MARRIED 8 DATE OF BIRTH (n years IF UNDER 1 YEAR NEVER MARRIED birthdoy) Manths Hours Sept. WIDOWED DIVORCED 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY
TIMBER Maryland Laborer 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Ida Downs Eleck Jones WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (If yes give war ar dates of service) Josh Jones Salisbury, Md. 222-09-78 XX XX INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) ONSUL AND DEATH burial-transit PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) signed by attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (o), DUE TO storing the underlying couse as the TO FUNERAL DIRECTOR: After this certificate has been WAS AUTOPSY PERFORMED? YES Z NO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) x2 exe ind fe 20g ACCIDENT WAS UNDERLYING [285 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (State) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (County) Hour a.m factory, street, affice bldg., etc.) Nat While at work at wark 196-70, 10 2). I certify that (1) (this haspital) attended the deceased fram Sent 000 , 19 Gz. that (1) (we) last 21 shauld directar, page 3 shauld shauld be filed with the 19 67, and that death accurred at 750 M, from causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 22o, SIGNATURE ATTENDING DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) 23d LOCATION (City or Town) Whaleyville 23a. BURIAL, CREMATION RENDVALTS DECEMEN 23b. DATE THEREOF 10/10/67 23c NAME OF CEMETERY OR CREMATORY (County) (Stote) Dale Wordster 25b. REGISTRAR'S SIGNATURE Wa. 25g. REC'D BY REGISTRAR FUNERAL DIRECTOR VR A15 (4)



		Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
2		TEE45 CERTIFICATE OF DEATH
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certific g phys Then p moval,		ALBERT CLARK KENLY LILIAN MILLER
e death certificate by attending physician permit. Then please on, ar removal, and i	15 (У	es, no arynknown) (If yes gryf war ar dates of service) Mas Walter NIKHULY BERUIT MO
O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after deal Page 4 may be retained by the haspital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funera directar, page 3 shauld be detached far use as the bunal-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Dept. af Health priar ta burial, cremation, ar removal, and in any evests within 72 transfer deal		INTERVAL BETWEEN SHART 1. DEATH WAS CAUSE (a) IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave (a), stating the underlying cause (a), stating the underlying cause (a) (c)
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IG PHY the ho r this of detoch	MEDICAL	20c TIME OF INJURY Manth, Doy, Year 20d INJURY OCCURRED 40e PLACE OF INJURY (Hame, farm, factory, street, office bldg., etc.) P.m 19 of work at work 19 of work 19 o
ENDIN ned by R: Afte uld be the Sta		21. I certify that (1) (this hospital) attended the deceased fram 6-10, 1967, that (1) (we) last saw the deceased alive on 10-17, and that deoth occurred of 188 M, from causes and on the date stated above.
OR be red weed w		220 SIGNATURE M.D. ATTENDING MED. STAFF 22b. DATE SIGNED PHYS. DIRECTOR PHYS. 10-19-67
O HOSPITAL Page 4 may O FUNERAL I director, pag should be fil	L	NAME (Type) I'M. I. p. A. Insley Salesberry Kild
TO HO Page direct		BURIAL CREMATION, 236 DATE THEREOF 23c. NAME OF CEMETERY OF CREMATORY OR MOVAL (Specify) 1 0 2.0 67 ST. (200 NO. 1) 23c. NAME OF CEMETERY OF CREMATORY ST. (200 NO. 1) 23d. LOCATION (City or Town) (County) (Stote) ST. (200 NO. 1) 25c. REGISTRAR SIGNATURE,
VR A15 (4)	2	FUNERAL DIRECTOR ADDRESS 25d. REGISTRAR S SIGNATURE PLAN OCT 2 3 1967

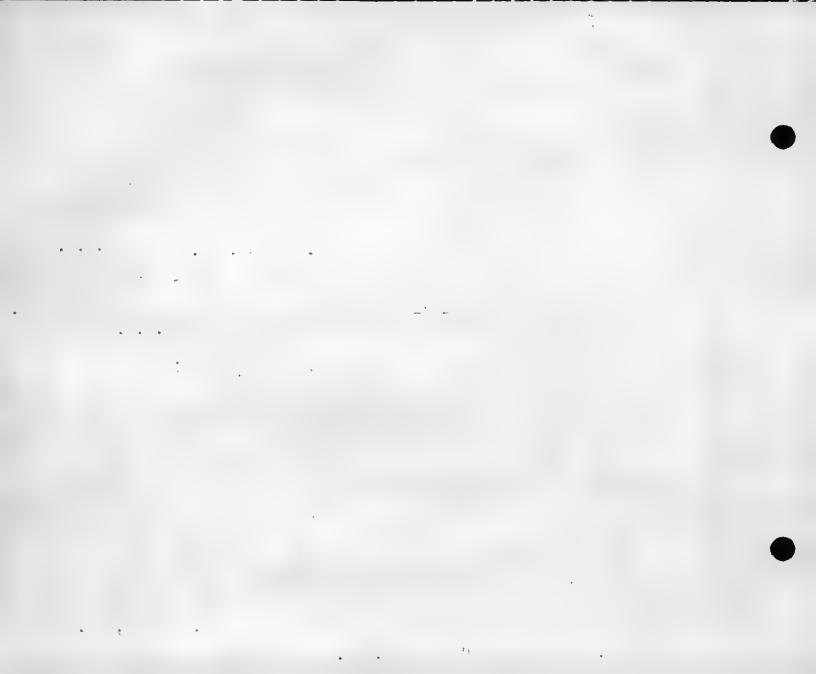
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE. MARYLAND 21201 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Wicomico MARYLAND 24 haurs after ours after b CITY OR TOWN (If outside corporate limits, SALIS DULY) CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS Peninsula General Hospital YES NO NO The law requires that the death certificate be executed within Middle 3 NAME OF 4 DATE Year First Lost Doy the attending physician and campletely, sit permit. Then please remave carban DECEASED AIRI 19 Type or print) DEATH IF LINDER 1 YEAR IF JNDER 24 HRS DATE OF BIRTH S SEX in years 6 COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthday) Months Dovs Hours WIDOWED DIVORCED 12 CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 10o, USJAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABOR INDUSTRY MT. VERNON, MD.

14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME CLIFTON LAIRD ELIZABETH BLOODSWORTH 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, ar unknown) (If yes give wor or dotes of service) 16 SOCIAL SECURITY NO. 17. INFORMANT 15-36-1187 MRS CLIFTON LAIRD PRINCESS būrial-transit perr burial, crematian, INTERVAL BETWEEN R.F.D.1 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: 1remin IMMEDIATE CAUSE (o) signed by 1 DUE TO Canditions, if any, which gave rise to immediate cause (o), DUE TO stating the underlying couse be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been far use as the 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES NO 200 ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item IB.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED Not While foctory, street, office bldg, etc.) of work of work 2). I certify that (I) (this hospital) attended the deceased from 1967, that (I) (we) lost 196 19 67, and that death occurred at ALA M. from couses and on the date stated above sow the deceased alive on 22a. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR PHYS 22d ADDRESS 22c. PHYSICIAN S NAME (Type) director, shauld b 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) 23o. BURIAL, CREMATION, (County) BURIAL (Specify) 10/16/1967 ASBURY CEMETERY VERNON. 2Sb. REGISTRAR'S SIGNATURE **ADDRESS** 25o. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 EVIN R. WILSON PRINCESS ANNE. MD.



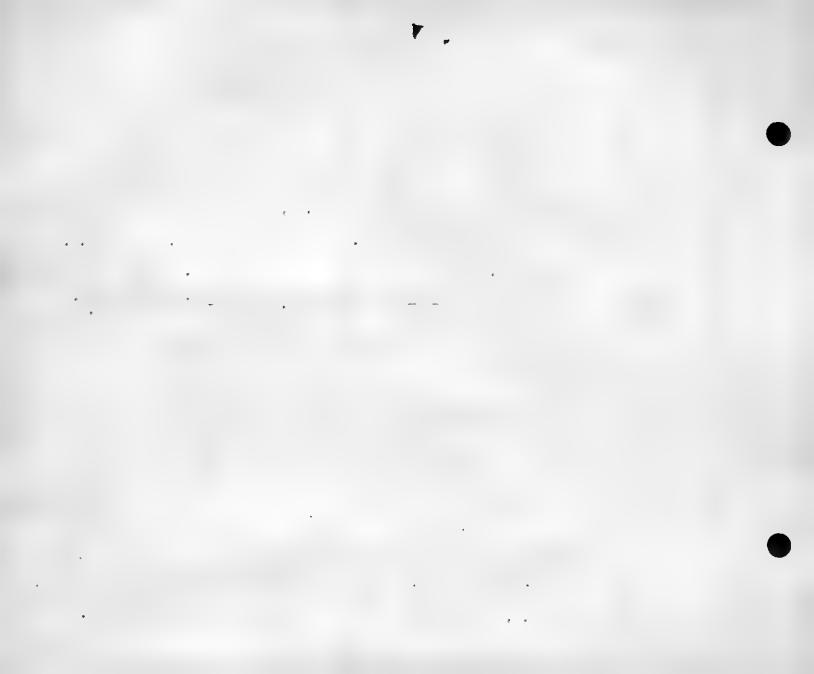
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 14657 2 USUAL RESIDENCE (Where deceased fixed, if institution Residence before admission) PLACE OF DEATH Wicomico o. COUNTY o STATE b. COUNTY Maryland MARYLAND Worcester 24 hours ofter c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) b. CITY OR TOWN (If outside corporate limits, c IENGTH OF STAY IN 16 write RURAL and give nearest town)
Salisbury 129 days Poc omoke d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Deer's Read State Hospital Fifth W 203 Linden Avenue YES NO SE requires that the death certificate be executed within carbon 3. NAME OF First 4. DATE Year DECEASED WALTER HUGH LONG (Type or pant) DEATH 6. COLOR OR RACE DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED X **NEVER MARRIED** lost bythday) and in ony WIDOWED DIVORCED 10a, USUAL OCCUPAT ON (Give kind of work done 10b KIND OF BUSINESS OR Somerset County. 12 CITIZEN OF WHAT during most of working life, even if retired)
Farming Farming COUNTRY? II.S. 13 FATHER S NAME MOTHER'S MAIDEN NAME burial-transit permit. Then permit burial, cremotian, ar removat, Lola Emma Gibbons Woodland A. attending IS WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no. or unknown) ((If yes give war or dates of service) 16 SOCIAL SECURITY NO 17. INFORMANT 217-36-0013 Mrs Rose Long, Pocomoke City, Md. 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) INTERVA, BETWEEN PART I DEATH WAS CAUSED BY SONSET AND DEATH Uremia IMMEDIATE CAUSE (o) signed by Hypertensive Arteriosclerotic Cardiovascular DUE TO Conditions, if ony, which gove Renal Disease vears rise to immediate couse (o), DUE TO stoting the underlying couse the 19 WAS AUTOPSY PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) PERFORMED? Broncho pneumonia (several days) 2. Chronic Gout NO IX certificate for 200 ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (C ty or town) (Stote) TO HOSPITAL OR ATTENDING PHY Page 4 moy be refored by the h TO FUNERAL DIRECTOR: After this Not While Hour em factory, street, office bidg., etc.) 21. 1 certify that (A) (this haspital) attended the deceased fram August 24 1966, to October 271967, that (A) (we) last saw the deceased alive an October 27 1967, and that death accurred at 2:20 PM, from causes and an the date stated above 226 DAJE SIGNED 10/27/67 DIRECTOR director, poge 3 should be filed Mary land "HYSICIAN'S 22d ADDRESS NAME (Type) C. H. Winnacott, M. D. Deer's Head State Hospital, Salisbury 234 NAME OF CEMETERY BIRX PENADORY BUR AL, CREMATION, 23b DATE THEREOF 23d LOCATION (City or Town) (County) (Stote) REMOVAL (Specify)
Burial 10-30-1967 Presbyterian Pocomoke City-Wor.-Md. 2So REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Minutes Judge NOV 1 1967 San Pocomoke City, Md. DATE Watson





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14659CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH a. COUNTY b. COUNTY Wicomico requires that the death certificate be executed within 24 haurs after MARYLAND SOMERSE b. CITY OR TDWN (If outside corporate limits, c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Salisbury WESTOVER d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B IS RESIDENCE ON A FARM? d. STREET ADDRESS Peninsula General Hospital YES NO X NAME OF Middle 4. DATE DECEASED OF DEATH camplete (Type or print) IF JNDER 1 YEAR 9. AGE (In years 7. MARRIED NEVER MARRIED Jost birthdoy) Doys DEC.26,1894 DIVORCED X WIDOWED 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED PNDUSTRY SHELLTOWN. MD. 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME LILLIE SMITH WILLIAM V. MATTHEWS 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address (Yes, no, ar unknown) (If yes give wor or dotes of service) OW ING MILLS, MD. MR. GERALD MATTHEWS INTERVAL BETWEEN ONSET AND DEATH 18 CAUSE OF DEATH (Enter only one couse per line for (o) (b), ond (c))
PART I. DEATH WAS CAUSED BY. transit signed by 1 burial-trans IMMEDIATE CAUSE (6) DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO stating the underlying couse the PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO FUNERAL DIRECTOR: After this certificate 200 ACCIDENT WAS UNDER YING LUOR CONTRIBUTING LOCAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 205. DESCRIBE HOW INJURY OCCURRAD, (Enter noture of injury in Port I or Port II of item 18.) 20d INJURY OCCURRED 20s. PLACE OF INJURY (Home, form, 20f. (City or town) (Stote) 20c TIME OF INJURY Month, Doy, Year (County) foctory, street, office bldg., etc.) Not While of work . 196 (that (I) (we) last 21. I certify that (I) (this haspital) organized the deceased fram_ I, and that death accurred at 700 M, from causes and an the date stated above. saw the deceased alive an 22o. SIGNATURI 22b. DATE SIGNE ATTENDING DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S directar, po NAME (Type) 230. BURIAL, CREMATION, BUREMOXAL (Specify) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) /1967 MANOKIN PRINCESS 250. REC D BY REGISTRAR 24. FUNERAL DIRECTOR Marley VR A15 (4) R. WILSON PRINCESS ANNE.





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14661

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	エコンジム	,		CERTII	FICATE	OF DEATH	ł			100	r.
	PLACE OF DEATH a. COUNTY	icomico		MAR	RYLAND	2. USUAL RESIDEN		eased wed, if inst b. Cl	itution Residen	ce before a	idmissian)
	b. CITY OR TOWN (I write RURAL app S	f autside carparate limit give_nearest town) alisbury	s,	LENGTH OF STAY		1	isbury	orate limits, write	RURAL and give		
		at or institut on (if a eer's Head		*		d. STREET ADDREST		Street		e II C YES	S RESIDENCE ON A FARM?
	NAME OF DECEASED (Type or print)	BAT	irst TTE	Middle		NCXIM	4 DATI OF DEA		lonth 10	Day 23	Yeor 19 67
	M M	6. COLOR OR RACE	7 MARRIED WIDOWED	NEVER MARRIE		Oct. 12,1		9. AGE (In years last bythdoy 68 yrs) Manths	Doys F	Hours Min
dur R	ring most of working	(G ve kind of work dane lile, even if retired) Inland Fist	IN IN	IND OF BUSINESS OR IDUSTRY		Atlanta, 14. MOTHER'S MAI	Georgi		CO	IIZEN OF W UNTRY? ISA	HAT
	es, no, or unknown)	XON RINUS. ARMED FORCES? (If yes give wor or dotes War I	of service)	SOCIAL SECURITY NO. 4-07-1155		Unkown NFORMANT Mrs. Luci 604 Light	lle S.	Mixon (V	ddress Vife)	aryla	and
		, which gove e cause (a),	(c) <u>Cere</u>	(o), (b), and (c), ebral Vasc ertensive						3 Ye	val Between 2 month ears
CERTIFICATION	PART II OTHER SI	GNIFICANT CONDITIONS		TO DEATH BUT NOT RE		- to do not				PE YES	AS AUTOPSY REORMED? NO X
MED CAL CERT	OR CONTRIBUTING (IF EITHER, NOTIFY	CAUSE OF DEATH MEDICAL EXAMINER) JRY Month, Day, Year n.	2Dd II	NJURY OCCURRED Nat While at work	20e PLA	CE OF INJURY (Hame ary, street, affice bldg	, farm, 20f	,		uniy)	(Stote)
	21 certing saw the de	fy that (X) (this have ceased alive an	spital) attend	ded the deceased	framSe	ptember 1 death occurred	3, 19 67 1 019:50A	ta <mark>Octobe</mark> M, from cause	es and on ti	ne dote s	stated above
	22c PHYS CIAN'S NAME (Type)	C. H. Win	nacott,	(C), M. D.	J.M.	22d ADDRESS	MED DIRECTOR	STAFF PHYS tate Hos	10,		7 yland
L	a. BURIAL CREMATION REMOVAL (Specify Bur 1 a	0ct. 26		23¢ NAME OF CEA Mt. Zion		tery		LOCATION (City or Augusta	. W. Vi	(County) rgini	(State)
2	4. FUNERAL DIRECTO	R Y & COMPAN'	Y. SALT	SBURY MAI	RYI AN		OCT 2	1967 25b	REG STRARS S		edge.

HOLLOWAY & COMPANY, SALISBURY, MARYLAND

Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending pllysician and campletery filled in by tairector, page 3 shauld be detached far use as the burial-transit permit. Then please remaye carbon papers. Pashauld be tiled with the State Dept. af Health priar ta burial, crematian, or removal, and in any event, within 72 hours. VR A15 (4) 25M 1/67

24 haurs after death

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed

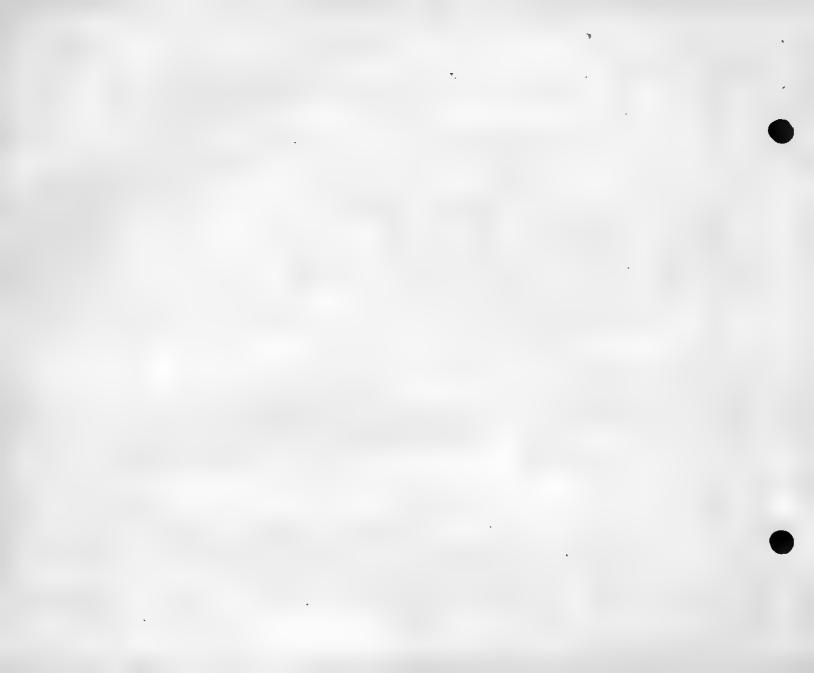


	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND	LAND 21201
	CERTIFICATE OF DEATH	14662
ī	PLACE OF DEATH o. (OUNTY Wicomico MARYLAND 2 USUAL RESIDENCE (Where deceased lived, if institute to the county of	
	b CITY OR TOWN (if autside carparate limits, write RU SALISOURY) C INGTH/DF STAY IN 1b C CITY OR TOWN (if outside carparate limits, write RU SALISOURY)	//
	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Peninsula General Hospital 660 W Maiso	e. IS RESIDENCE ON A FARM?. YES NO
3	NAME OF DECEASED (Type or pr nt) SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 1 8 DATE OF BIRTH 1 9 AGE (In years)	ber 11 1967 VIF LADER 1 YEAR 1 IF UNDER 24 HRS
10	Mile C WIDOWED DIVORCED 10-10-6 / lost birthday)	Months Doys Hours Min
	INDUSTRY 3. FATHER'S NAME 14 MOTHER'S MAIDEN NAME	country? S.A.
L	FLIEN TERRY REMEMBRA	NEAL
(S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Addr Tes, no, or unbound? Stress give wor or dates of service) Addr SUND 1	ck
	18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7 7 6 X IMMEDIATE CAUSE (o) DUE TO 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). 7 7 6 X DUE TO	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if any, which gave nse to immediate cause (a), stoting the underlying cause (b) DUE TO (c)	
ATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19 WAS AJTOPSY PERFORMED? YES NO
A CERTIFICATION	206 ACCIDENT WAS UNDERLYING 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
MFDICAL	20c TIME OF INJURY Manth Day, Year Haur o m. 19 20d INJURY OCCURRED While at work at work office bidg etc.) 20e, PLACE OF INJURY (Home, form, foctory, street, office bidg etc.)	(County) (State)
	21. I certify that (I) (this haspital) attended the deceased from 10 10 , 19 67, 10 67 saw the deceased alive an 10 11 19 67, and that death occurred at 12 M, from causes	// , 1967, that (1) (we) la ond on the dote stated abov
	22a. SIGNATURE DS CLOSE M.D. ATTENDING MED DIRECTOR DIRECTOR PHYS. C	22b DATE SIGNED
	22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS	
2:	30. BURIAL CREMATION, 23b DATE THEREOF 23c MAME OF CEMETERY OR CREMATORY 23d KOCATION (City of To REMOVAL (Specify) 9-1467 Secul Acres Dakisher	own) (County) (Stote)
		EGISTIMAR'S SIGNATURE





, 1	1	MARYLAND STAT Division of STATISTICAL RESEARCH AND RECORD		ARTMENT OF HEALTH	ODE MADVIAND 212	01
			-		JRE, MARILAND 2120	31
= (AM)			CAIL	OF DEATH	17	1664
funeral		PLACE OF DEATH COUNTY TA		2 USUAL RESIDENCE (Where deceased a. STATE	lived, if institution Residence b. COUNTY	i before odmissian)
after after be fur after after		W1.COM1.CO MARYLA		c, CITY OR TOWN (If odtside corporate	Wor	cerstar
hours after n by the fi s. Poges hours afte		S. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Sallsoury	10	Snow Hil	MILIES, WITE KUKAL ONG GIVE	Heritazi 10 Mil)
24 hou		J. NAME OF HOSPITAL OR INSTITUTION (1f nat in haspital, give street address)		d STREET ADDRESS	,	e IS RESIDENCE ON A FARM?
within 24 milled my 72 within 72		Peninsula General Hospital		Federal.	57.	YES NO NO
d within letely fill groon	3	NAME OF First Middle DECEASED Type or print) The first Middle Collection Type or print)	1	Lost 4 DATE	Month	Doy Year
en tropo		Type or print) EX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED		DATE OF BIRTH 9.	AGE (In years IF UNDER)	5 19 6 7 YEAR IF UNDER 24 HRS
teoth certificate be executed ending physician and complemit. Then please remove to or removal, and in any even	ľ,	ncle White WIDOWED DIVORCED				Days Hours Min.
ond rem	10a	USJAL OCCUPATION (Give kind of work dane 106 KIND OF BUSINESS OR 100 most of working life, even if retired) INDUSTRY		11. BIRTHPLACE (County & Store, or foreig	n country) 12 CTs	ZEN OF WHAT
ertificote be physician c nen please coval, ond ii	QUI	LASHrance Agent General L	115	Snow Hill 1	ryd 4	NIRY?
tifice hysi n pl val,	13	FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
ng p The	75	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.	77 IN	ISlanche Lrw	Address	
equires that the deoth ce physician. signed by the attending buriol-transit permit. The	(Ye	s, no, or unknown) (If yes give wor or dates of service)	Mar	Willia I No	K Snew H	1:11 Hel
equires that the d physician. signed by the att burial-transit pen burial, cremation,		1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),)	1///3.	1 The Ville	10	INTERVAL BETWEEN
quires thot t physician. signed by the buriol-transit		PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (0)	acl	butter Hear	3 Weekerl	ONSET AND DEATH
es the sicion ed boutto		Y + U O DUE TO Conditions, if any, which gave) (b)		- 0		
equir phys sign buric		rise to immediate cause (a).				
w re ding een the r to		stoting the underlying couse last.				
The low requires the attending physician. has been signed by se as the buriol-traith prior to buriol, cre	22	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELAT	TED TO TH	IE TERMINAL DISEASE CONDITION GIVEN	IN PART 1(a)	19 WAS AUTOPSY PERFORMED?
or o	CATIO					YES NO
TO HOSPITAL OR ATTENDING PHYSICIAN: The flow requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completery filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please remove tarbon patters. Pages 1 and should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in any event, within 72 hours after peaks.	L CERTIFICATION	200. ACCIDENT WAS UNDERLYING ☐ CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	URRED (E	inter nature af injury in Part I or Part I	of item 1B.)	
PHY he ho	MEDICAL	20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 2 Hour o m. While Not While		OF INJURY (Hame, farm, 20f. (City or town) (Cour	nty) (State)
NG by the ter t	×	p.m. 19 at work U at work U			177 - 65 100	
OR ATTENDING be retoined by the iRECTOR: After the 3 should be ded with the Stote		21. I certify that (I) (this hospital) attended the deceased fi		deoth occurred at 1/A M,		1, that (1), (we) last
R ATTEN retoined RECTOR: A 3 should with the		220. SIGNATURE	10 11701		22b. DA	TE SIGNED
OR Director of the property of		Ludde Q. allest	M.D	ATTENDING MED. PHYS DIRECTOR	STAFF PHYS. D	5-67
TAL De Pos		22c. PHYSICIAN'S NAME (Type)		22d ADDRESS	·	
O HOSPITAL Poge 4 moy O FUNERAL I director, pog should be fill	230	BURIAL CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETE	ERY OR CR	REMATORY. 23d LOCA	TION (City or Town) ((State)
S S S S S S S S S S S S S S S S S S S		Surial (Specify) Cet. 8,1967 Makemie M	lener	is/ PresbyTens 5.	now Hill 1	111.
VR A15 (4)	24	FLINERAL DIRECTOR ADDRESS		256. REC'D BY REGISTRAF	25b. REGISTRAR'S SIG	SNATURE
20 M 1/66	-	Emman F. Homes Snow He	//	Mal DATE OCT 9	1967 Julian	iles Judges.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14658 14665 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE b. COUNTY Wicomico Maryland Wicomico MARYLAND b CITY OR TDWN (If outside corporate limits write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate timits write RURAL and give nearest town) c LENGTH OF STAY IN 16 29 days Salisbury Salisbury d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS 207 New York Avenue Deer's Head State Hospital YES NO Middle NAME OF DATE Month Year DECEASED Nancy Blanche Payne October 19 67 signed by the ottending physician and complete burial-transit permit. Then please remove carb burial, crematian, or removal, and in any event, (Type or print) DEATH S SEX 9. AGE (In years IF UNDER 1 YEAR 6 COLDR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH IF UNDER 24 HRS lost birthday White Hours Female WIDOWED -DIVORCED 1Do USJAL OCCUPATION (Give kind of work done during most of working life even if retired) 10b KIND OF BUSINESS OR 12 CIT ZEN OF WHAT COUNTRY? INDUSTRY Greenbackville, Va. 13. FATHER'S NAME Own Home IS. WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) 220 52-8107 Roger W. Payne, Salisbury, M.C. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Acute coronary and pulmonary edema IMMEDIATE CAUSE (o). Page 4 may be retained by the haspital or attending physician 420 DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate hos been director, page 3 should be detoched far use as the shauld be filed with the Stote Dept. of Health prior to PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? Fracture of pelvis, right pubis and ischium; diabetes mellitus. NO K 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port or Port II of Item 1B.) 2Do ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 2Dd INJURY OCCURRED 2De PLACE OF INJURY (Home form, (City or town) (County) (State) Not While Hour Tolm. factory, street, office bldg , etc.) of work 10/11 19 67, that (I) (we) lost 21 I certify that (1) (this hospital) attended the deceased from..... 19 67. to sow the accessed olive on 10/11 19 67, and that death occurred at 12:45, from causes and on the date stated above 22b DATE SIGNED 22o. SIGNATURE MED DIRECTOR 10/11/67 Deer's Head Hospital; Salisbury, Md. NAME (Type) A. C. Mitchell, M. D. 230 BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) ((ounty) REMOVAL (Specify)

24. FUNERAL DIRECTOR Stockton 250. REC D BY REGISTRAR VR A15 (4) 25M 1/67



RESTON STREET, BALTIMORE 1, MARYLAND STATISTICAL RESEARCH AND RECORDS, 301 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceated lived, Il institution; Residence before edmission) 1. PLACE OF DEATH a. COUNTY **b. COUNTY** Wicomico Mar v 1 and Wicomico MARYLAND 2 2 2 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) b. CITY OR TOWN (il outside corporete limits, LENGTH OF STAY IN 16 write RURAL and give necrest town? Adm. in Id 9/30/67 Hebron Salusbury d. STREET ADDRESS a. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ON A FARM? Walnut Street Peninsula General Hospita YES NO 4. DATE NAME OF Erest Middle Month Year DECEASED 67 October PHILLIPS LULA BFRTIE DEATH 19 (Type or print) and cor 9. AGE (In years IF UNDER I YEAR | IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE 7. MARRIED XX NEVER MARRIED 8 DATE OF BIRTH lest_birthdey} Months Days Hours Min. White Female DIVORCED August 8.1889 WIDOWED 10s. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? 1Db. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired! Worcester County, Maryland USA Shirt Factory Retired Seamstress 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME please Sarah Elizabeth Dickerson John Henry Shockley Sarah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17 INFORMANT Oscar Lee Phillips (Husband) 477, Hebron, Maryland (Yes, no, or unknwn) | (Ill yes give we for detes of service) 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c), INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which seve rise to immediate cause. **DUE TO** (e), stating the underlying enuse last PARK II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(4): 19. WAS AUTOPSY CATION PERFORMED? NO P 20b. DESCRIBE HOW INJURY OCCURED. (Inter nature of injury in Part I or Pert II of item 18.) GRIFF 2Da. ACCIDENT WAS UNDERLYING 1 7/ OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, Jarm, 20f. (City or town) (County) (Stele) 20c. TIME OF INJURY Month, Doy, Year fectory, street, office bldg., etc.) While Not While Hour a.m. et work et work 21. I certify that (I) (this hospital) attended the deceased from.......... --Apb--9P M/ from the causes and on the date stated above .19.0 and that death decurred at saw the deceased alive on DATE 22a. SIGNATURE SIGNED MED STAFF DIRECTOR PHYS. MD October 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Q./ J. Medical Center, Salisbury, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 23a. BURIAL, CREMATION. | 23b. DATE THEREOF REMOVAL (Specify) S.g. Z Salisbury, Maryland Dctober 5,1967 Wicomico Memorial Park REC'D BY REGISTRAR 256, REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** VR A15 (4 HOLLOWAY & COMPANY, SALISBURY, MARYLAND 1SM 7-62

physician

attending

FUNERAL



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission, B. COUNTY **b.** COUNTY Wicomico MARYLAND Maryland Wicomico b. CITY OR TOWN (if outside corporate limits, E. LENGTH OF STAY IN 16 c, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town Hebron Hebron d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? 111 Railroad Avenue Railroad Avenue YES NO J. NAME OF 4. DATE Yeer Middle Lest DECEASED OF (Type or print) DEATH MYRTLE **EMMA** PHIPPIN October 19 67 6. COLOR OR RACE 7. MARRIED XXNEVER MARRIED AGE (In years | IF UNDER) YEAR DATE OF BIRTH IF UNDER 24 HRS. last birthday) and Months Hours DIVORCED WIDOWED [Female lWhite July 22,1895 physician 10a. USUAL OCCUPATION (Give kind of work TOL. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY! done during most of working life, even if retired) Wicomico County, Maryland <u>Housewife</u> USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending James Fitzgerald Alice English ā 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknwn) | (Ifyes give werordates of service) Mr. Marion C. Phippin (Husband) No ng physician. Railroad Ave. Hebron, Maryland 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (g)? INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which (b) geva rise to immediate cause DUE TO (a), steting the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(+): 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO 20a, ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED (Enter neture of murry in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Month, Dev. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm. 20f. (City or town) (County) (State) Not While factory, street, office/bldq., etc.) Hour a.m. at work | et work | p.m. 21. I certify that (I) (this hospital) attended the deceased from..... ECT and that death occurred at a...M, from the causes and on the date stated above saw the deceased alive. 22b, DATE 22a. SIGNATURE SEGNED ATTENDING STAFF DIRECTOR uro M.D. October death. Page 4 22d. ADDRESS 22c. Physician's Medical Center, Salisbury, Maryland David J. director, Filed v 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, town or county) (State) 23a, BURIAL, CREMATION, 23b DATE THEREOF REMOVAL (Spacify) Burial Oct. 26,1967 | Nelson Memorial Cemetery Hebron, Maryland 256, REC'D BY REGISTRAR 256, REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) HOLLOWAY & COMPANY, SALISBURY, MARYLAND 1SM 7-62

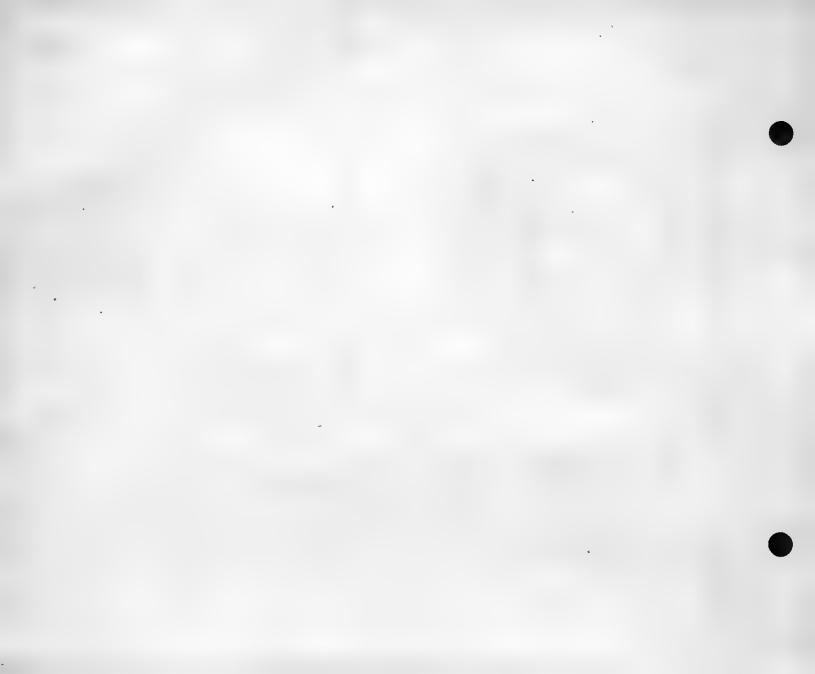
RYLAND STATE DEPARTMENT OF HEALTH



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13. FATHER'S NAME ACRO	Ma	Le Neyvo W	IDOWED DIVORCED ,	10-3-67	last birthday) Mai	nths Days Haurs Min.
15. WAS DECRAFD EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war ar dates of service) 16. SOCIAL SECURITY NO. 17 INFORMANT Address PO Boy 3/2 Interval Between Part I. DEATH (Enter only one couse per line for (a) (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO DUE TO Conditions, if ony, which gave rise to immediate cause (a), stoting the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION GIVEN IN PART I (d) PART II. DEATH WEEK PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION GIVEN IN PART I (d) PART II. DEATH WEEK PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) PART II. DEA	during ma	st af warking life, even ıf retıred)		Wicomico Cour	e, or foreign country) ty, Maryland	COUNTRY?
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Dest. Contribution Contribution Contribution Death but not related to the terminal disease condition given in Part 1(a) 19. Was autopsy Performed? Yes No Dest Contribution 20a. Accident was underlying 20b. Describe how injury occurred. Contribution Con	rise t	litions, if ony, which gave (b)	Premeterity	- (a# 11	(203)	42 25"
20a. ACCIDENT WAS UNDERLYING 20a. ACCIDENT WAS UNDERLYING (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Haur o.m. p.m. 19	lost.	(c)_	IBUTING TO DEATH BUT NOT RELATED TO T	HE TERMINAL DISEASE CONDITIO	N GIVEN IN PART 1(o)	19. WAS AUTOPSY
20c. TIME OF INJURY Month, Day, Year Haur o.m. p.m. 19	ERTIFICATIO OB (ONTRIBUTING CAUSE OF DEATH	205. DESCRIBE HOW INJURY OCCURRED.	Stillborn Enter nature of injury in Part I	ar Port II of item 1B.)	YES NO
21 certify that (I) (this haspital) attended the deceased fram 0 3 19 6 ta 10 5 19 6 ta 10 5 19 6 ta 10 ta		TIME OF INJURY Month, Day, Year Haur o.m.	While Not While foote	CE OF INJURY (Home form, pry, street, office bldg., etc.)	20f. (City ar town)	(Caunty) (State)
M.D. ATTENDING MED. STAFF I 10 5167		21 I certify that (I) (this haspita) attended the deceased fram			, 19 6), that (I) (we) lo an the date stated above
22c. PHYSICIAN'S 22d. ADDRESS		'W> Ch	leon M.C	ATTENDING MED. PHYS DIRECT	STAFF C	2b. DATUSIGNED
	RM	OVAL (Specify) 10-7-6	1 New Bether		Berlin - W.	(County) (State)
REMOVAL (Specify) 10-7-67 New Bethel Berlin - Warcestew - mid	24. FUN	retta & Jalley &	Jersey Carried 2	25° OCT BY	EGISTRI967 256 REGISTR	AR'S SIGNATURE OF THE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14670 CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY MARYLAND c. LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate imits, write RURAL and give nearest town) RUITLAND e IS RESIDENCE d. STREET ADDRESS ON A FARM? NO X YES Middle 4 DATE First Last Manth Doy Year 0F 8 BBS 19 67 DEATH 6 COLOR OR RACE AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED DATE OF BIRTH **NEVER MARRIED** Months last birthday) WIDOWED DIVORCED 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT COUNTRY? -INDUSTRY 01115 E 1611 14. MOTHER'S MAIDEN NAME 17. INFORMANT 16 SOCIAL SECURITY NO (If yes give war ar dates of service) AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **DUE TO** DUE TO WAS AUTOPSY PERFORMED? NO 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part + or Part II of item 18.) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) Haur a.m. factory, street, office bldg., etc.) While Not While

(County)

(State)

the funeral b CITY OR TOWN (If outside corporate limits. write RURAL and give negrest town) edale d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sabers NAME OF carban campletely DECEASED (Type or print) S SEX 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) gud 13. FATHER'S NAME ar remaya attending p IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, notor)unknawn) crematian, signed by the a burial-transit pe 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c).) burial, Conditions, if any, which gave rise to immediate cause (a), stoting the underlying couse has been last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) this certificate 20a ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Day, Year at work at wark TO FUNERAL DIRECTOR: After þe 21 I certify that (1) (this hospital) attended the deceased fram be retained 1967, and that death accurred at 300/AM, from causes and an the date stated above saw the deceased alive an_ 22a SIGNATURE 22b. DATE SIGNED director, page 3 shauld be filed v DIRECTOR M.D. 22d. ADDRESS TO HOSPITAL Page 4 may b 22L PHYSICIAN'S NAME (Type) ADKINS -RUITLAND ber 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION 23b. DATE THEREO 10CATION (City or Town) REMOVAL (Specify) 9 250. RECD BY REGISTRAR OCT 24

death

24. FUNERAL DIRECTOR

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death

VR A15 (4) 25M 1/67





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 063 CERTIFICATE OF DEATH 4672 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH o. COUNTY Wicomico a. STATE b. COUNTY. Wic omice MARYIAND The law requires that the death certificate be executed within 24 haurs after b. CITY OR TOWN (If autside corparate limits, C LENGTH OF STAY IN 15 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) the attending physician and completely (illed in by the write RURAL and give negrest town) Willards 5davs Salisbury e IS RESIDENC d. NAME OF HOSPITAL OR INSTITUTION (If pat in hospital, give street address) d. STREET ADDRESS n 72 ON A FARM? YES NO X Peninsula General Hospital cachon penty 3 NAME OF First Middle 4. DATE Day Year Last DECEASED Vaughn DEATH ((Type or print) 9. AGE (In years ast birthdoy) S SEX 6 COLOR OR RACE 7. MARRIED TT DATE OF BIRTH NEVER MARRIED Months Davs Haurs WIDOWED DIVORCED 12 CITIZEN OF WHAT 10n IISLAL OCCLPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) COUNTRY? during most of working life, even if refired) Hardware Marvland USA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME John kavne Manie Mitchell IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) [(If yes give wor or dates of service) 213-14-1752 Frances Rayne Willards. Md XX 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) attending physician. DUE TO Canditians, if any, which gave rise to immediate cause (a). **DUE TO** stating the underlying cause at the prior to O FUNERAL DIRECTOR: After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 160 WAS AUTOPSY USE CERTIFICATION NO be retained by the haspital ar for 20a ACCIDENT WAS UNDERLYING I 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED (City or tawn) (State) 20c. TIME OF INJURY Month, Day, Year 20e PLACE OF INJURY (Home, farm, (Caunty) foctory, street, office bldg, etc.) Haur o.m. Not While at wark 21. 1 certify that (1) (this hospital) attended the deceased from 10-14-67. 19 to 10-21-6319_, that (I) (we) last ____ and that death accurred at C saw the deceased alive on 10-21-67 19 M, fram couses and an the date stated above. 22g. SIGNATURE 22b DATE SIGNED MED.
DIRECTOR 0-22-67. M.D 22d. ADDRESS PHYS CIAN'S Jeseph U. Fitzgerald NAME (Type) SALISBURY ARYLAND director, shauld 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23b DATE THEREOF 23g, BURIAL CREMATION REMOVAL (Specify) 10/24/67 notionala. Pudal VR A15 (4) DATE POT 1 E 1007 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 74664 14673 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 haurs after death popers Peges 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY a STATE b COUNTY Wicomico MARYLAND Marvland Caroline b. CITY OR TOWN (If outs'de corparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b c EITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury mos. -23days Ridgely d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d. STREET ADDRESS filled Deer's Head State Hospital NO In NAME OF Middle 4. DATE Year remove tarbo DECEASED completel (Type or print) DEATH Anderson burial, cremotion, or removal, and in any eyent Steven Redden 9 AGE (In years IF UNDER 6 COLOR OR RACE **NEVER MARRIED** 8. DATE OF BIRTH 7. MARRIED Haurs WIDOWED DIVORCED Male White gud IDo USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CIPIZEN OF WHAT during mashof working life, even if retired) attending physicion of permit. Then please INDUSTRY Jan 0~~~ 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war at dates of service) RODGELY MU INTERVAL BETWEEN CHISET AND DEATH 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the burial-transit p PART I. DEATH WAS CAUSED BY-Broncho Pnuenomia IMMEDIATE CAUSE (o). O HOSPITAL OR ATTENDING PHYSICIAN: The law requires me Poge 4 moy be retained by the hospital or ottending physician. DUE TO Conditions, if any, which gave Chronic Pyelonephritis years rise to immediate cause (a), DUE TO stating the underlying cause age 3 should be detached for use as the filed with the State Dept. of Health prior to WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 3 Chronic Hypertrophic Osteoarthritis - Chronic Emphysema FUNERAL DIRECTOR: After this certificate 200 ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW IN JRY OCCURRED, (Enter nature of nory in Part or Part II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dd INJURY OCCURRED 2De PLACE OF INJURY (Hame, farm, (City ar town) (County) (State) 20c. TIME OF INJURY Month, Doy, Year factory, street, affice bldg , etc.) Haur a.m. at work at work 21. I certify that (1) (this hospital) attended the deceased from Sent. 6. , 1967 to October 29, 1967, that (1) (we) last saw the deceased alive an October 29 19 67, and that death accurred at 1036 M, from causes and on the date stated above. 22b DATE SIGNED M.D DIRECTOR PHYS PHYS 10/29/67 director, page should be filed Deer's Head State Hospital, Salisbury, Mo 22c PHYS CIAN S C. H. Wingacott, M.D. NAME (Type) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. OCATION (City or Town) 230 BURIAL CREMATION (County) (Stote) 196 00 2 **ADDRESS** 25g. REC D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VR A15 (4) 25M 1/67

1967

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MARYLAND STATE DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14674 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. COUNTY P COUNTA-Maryland Wichmico comico MARYLAND b. CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) 7 illards Life d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? XX YES NO D The law requires that the deoth certificate be executed within 3. NAME OF Middle Lost 4 DATE Year Doy the ottending physician and completely sit permit. Then please remove carbox DECEASED OF DEATH Stella Mae Cooper Routzahn Oct. 196 burior, cremation, or removal, and in any event, Type or print) 19 IF JINDER I YEAR IF JNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH AGE (In years lost birthday) Months Doys Hours June White WIDOWED DIVORCED 11. h & male 10a USUAL OCCUPAT ON (Give kind of work done 106 KIND OF BUSINESS OR 11 BIRTHP-ACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of work ng life, even if retired)
Housevife COUNTRY? INDUSTRY Ноше Marydand Own. 13 FATHER S NAME 14. MOTHER'S MAIDEN NAME Mariah George Bratten IS WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) [(If yes give wor or dotes of service)] 16 SOCIAL SECURITY NO 17 INFORMANT Maward Cooper willards. Md 18. CAUSE OF DEATH (Enter only one couse per one for (o), (b), and (c)) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or ottending physician. DUE TO xheresex Conditions, flony, which gove rise to immediate cause (a). DUE TO stoting the underlying couse last 50 WAS AUTOPSY PERFORMED? PART I., OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO. OR ATTENDING PHYSICIAN: 20th DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Post or Port II of Item 18.) 20o ACC DENT WAS INDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form, (City or town) (County) (State) Hour gam. factory, street, affice blag, etc.) Not While of work at work **DIRECTOR:** After 21. I certify that (I) (this hospital) attended the deceased from director, page 3 should should be filed with the and that death occurred at II (M. frago causes and on the date stated above sow the deceased alive on, 220 SIGNATURE DATE SIGNED **ATTENDING** DIRECTOR 22d ADDRES3 22c PHYS CIAN S TO FUNERAL NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION 236 DATE THEREOF 23d LOCATION (City or Town) (Stote) 10/14/67 Willards Cooper ADDRESS 24 FUNERAL DIRECTOR VR A15 (4)

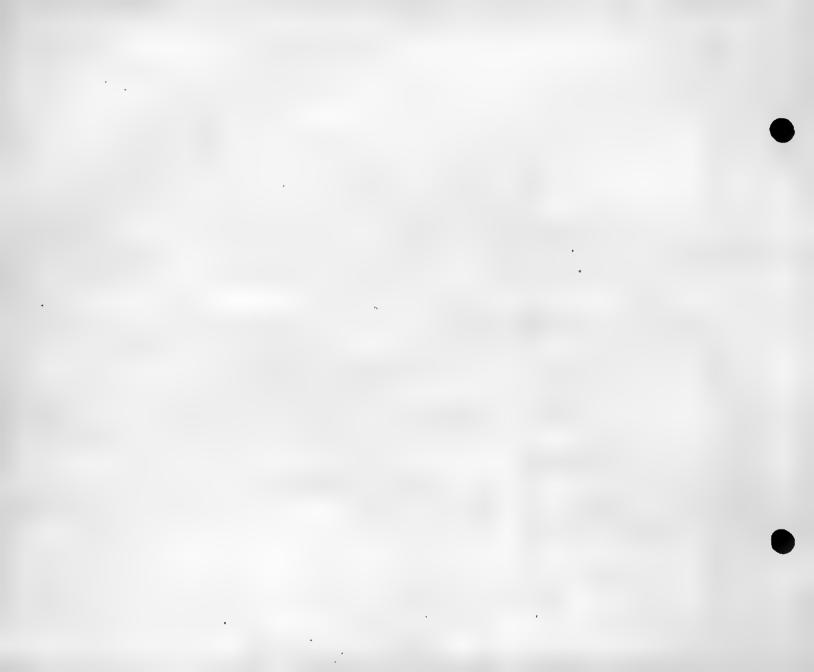


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14675 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **FOR STATE** HEALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before odmission) o COUNTY o STATE b COUNTY_ Wicomico MARYLAND b CITY OR TOWN (If outside corporate limits, LENGTH OF STAY N 1b c CITY OR TOWN (If outside carparate i,m ts. write RURA, and give nearest tawn) puo write RURAL and give nearest town) P.M3 Quantico Salisbury d NAME OF HOSP TAL OR INSTITLT ON (If not in hospital give street address) d STREET ADDRESS e IS RES DENCE ON A FARM? wuantico Peninsula General Hospital YES K NO [in penc.l im Item 18. Give Pages This certificate shauld be executed within 24 hours ofter death 3 NAME OF E rs1 Midd e Last 4 DATE Month Year DECEASED OF #he Edwin 10-22-67 John Sample DEATH 19 (Type or print) F UNDER 24 HRS S SEX 6 COLOR OR RACE B DATE OF BIRTH AGE (In years 7 MARRIED NEVER MARRIED lost birthday) Davs Haurs 6 WIDOWED DIVORCED 7-29-67 hours ofter death 10a USUAL OCCUPATION (Give kind of work done TOB KIND OF BUSINESS OR 11 BIRTHPLACE (State or fare on country) 12 CITIZEN OF WHAT during most of working life even if retired) INDUSTRY COUNTRY? Salisbury, Md.

14 MOTHER'S MAIDEN NAME USA farworded to the Chief Med cal Examiner's 13 FATHER'S NAME Shirley Reddick Leroy Sample Quantico, Md. IS WAS DECEASED EVER IN ILS ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT event within 72 (Yes, negationknown) (If yes give war ar dates of service Leroy Sample quantico, Maryland N RVAL BETWEEN 18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) burial-tronsit SEL AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) please execute the certificate, writing the word DUF TO dny Conditions, if any, which gave (b) nse to immediate couse (a), ⊆ DUE TO stating the underlying cause 0 ond 03 lost PART II OTHER SIGNIFICANT CONDITIONS CONTRIBLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE FOND TON GIVEN IN PART 1(0) WAS AUTOPSY or remayal, PERFORMED? NO YES = pe 20e. EXTERNAL CAUSE WAS PRIMARY □ or CONTRIBUTING □ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I at Part II of item 1B.) 3 should AL EXAMINER: SUDDEN DEATH IN INFANCY CAUSE OF DEATH 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) 20c TIME OF INJURY Manth, Day, Year (County) (State) factory, street, office bldg., etc.) Hour a.m Nat While at work at work 21 | certify that I took charge of the remains described above, held an Autopsy K. Inspection K. Ingu'ry 🛣 ond in my opinion deoth resulted from _Noturol couses 🛦 Accident Suicide Hom'cide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASS STANT MEDICAL EXAMINER prior SIGNATURE O DEPUTY DEPUTY MED CAL EXAM NER 10-23-67 Earl L. Royer, M.D. O FUNER Heolth 109 Camden Ave. Salisbury Md. NAME Type) Address (Street, city lawn or county) 23d COCATION (City or Town, 23g BURIA CREMATION. (County) (State) REMOVAL (Specify) 24/67 Cemetery Salisbury Green Md Euris nlcomico 24 FUNERAL DIRECTOR VR A15ME (5) DATEOCT 25 1967 6M 1/67

, 4.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14676 CERTIFICATE OF DEATH deoth. hours after death uneral l and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE b. COUNTY Micomico MARYLAND b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) write RURAL and give nearest town) event, within 72 hours IS RES DENCE ON A FARM? d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS requires that the death certificate be executed within 24 NO K Feninsula General YES 3 NAME OF DATE Doy Year the attending physician and completely sit permit. Then please remaye carban DECEASED OBER (Type or print) DEATH 19 IF UNDER 1 YEAR IF UNDER 24 HRS S SEX & COLOR OR RACE 7 MARRIED Months Hours WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 100. USUAL OCCUPATION (Give kind of work done 1]. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if ret red) NDUSTRY COUNTRY r.tor 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal, INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, nga or Chknown) (If yes give wor or dotes of service) crematian, INTERVAL BETWEEN IB CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) burial-transit ONSET AND DEATH PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). signed by DUE TO burial, Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse as the prior tak Page 4 may be retained by the haspital or attending O FUNERAL DIRECTOR: After this certificate has been last 19. WAS ALTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) for use YES A NO filtea fine 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18) 20a ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER directar, page 3 shauld be detache should be filed with the State Dept. 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Not While al work 21. I certify that (I) (this hospital) attended the deceased fram 9-30-, 1967, to 10-1, 1967 that (I) (we) last 10-1-19 6.7 and that death accurred at 10^{33} 4M, from causes and an the date stated above. saw the deceased abve an 22o. SIGNATURE 22b. DATE SIGNED ATTENDING N DIRECTOR M.D PHYS PHYS 22d ADDRESS 22c PHYSICIAN'S NAME (Type) id cal 23g-BURIAL, CREMATION 23b. DATE THEREOF NAME_DE_CEMETERY OR CREMATORY 23d/ NOCATION (City or Town) (County) REMOVAL (Specify) tacamake 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Willander



_	, MARYLAND STATE DE					
2	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 146'2'2					
TOD STATE	14.68 Item #7 Film #639 FYAMINED	CERTIFICATE OF DEATH				
FOR STATE	THEOTEAL EXAMINATE					
HEALTH DEPT.	I. PLACE OF DEATH O. COUNTY Wicomico	2 USUAL RESIDENCE (Where deceosed lived, if institution, Residence before admission) o STATE Mary Land b. COUNTY WICCOMICO				
B 30 5	MARYLAND					
deloy	b. CITY OR TOWN (If outside corporate limits,	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury Short	Pittsville				
Depoi Depoi	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d Street Address e is residence On a farm?				
form fe De	Peninsula General Hospital	Rural YES NO R				
# B # F	3 NAME OF DECEASED Manford First Middle	Lost 4 DATE Month Day Year				
ve Pag	NAME OF DECEASED Manford Franklin Shock	ley 0F 10-26-67 19				
₽ 5 E	S SEX 6 COVOR OR KACE 7 MARR ED X NEVER MARRIED	B DATE OF B RTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 MRS lost birthdoy) Months Doys Hours Min				
18.0 2 w 2 th.	M W DOWED DIVORCED	1-2-1907 60 yrs 10015 Milling				
hours tem 1 Office o≡d2 deotf	100, USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR	11 BIRTHPLACE (State or Toreign country) 12 CITIZEN OF WHAT				
24 hours in Item 18 ers Office gms 10md2 v	during most of working hile, even if retired) Painter INDUSTRY 1aborer	Wicomico Co. Md. USA				
hin 24 ncil in niner s magilis ars affe	13. FATHER S NAME	14. MOTHER'S MAIDEN NAME				
with peny armi	Arthur G. Shockley	Maggie Wells				
d with the Example File 72 how		INFORMANT Address				
executed nding" ir Medical I permit. (no (14 yes give wor or dotes of service) 216 18 8877	Lura W. Shockley Pittsville, Md.				
MINER: This cert ficote should be executed within 24 hours after death the certificate, writing the word "pending" in pencil in Item 18. Give Pages 4 should be forwarded to the Chief Medical Examiners Office along with for riles 3 should be med on a flurial-trons to permit, file mages load 2 with the State nation, or removal, and in any event within 72 hours after death.	TR. CALISE OF DEATH (Enter only one course per line for (a) (b) and (c))	ATTENIAL DETINEES				
be ''pe infrant	PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Coronary occlusion	HOUSE AND DEATH				
should be ne word "pe to the Chief mund-frons	4201 DUE TO					
we the triol	Conditions, if any, which gave) (b)					
te s the s d to	rise to immediate couse (a), (DUE TO					
ficoti fing fred rded on o	10st (t)					
cert t , writh orwar	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED 2				
This cert ficate, write be forward be forward be med be med removal,	20g EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED PRIMARY OF OF CONTRIBUTING OF CONTRIBUTING OF CONTRIBUTIONS OF O	YES NOX				
This icate, be fared by the far	200 EXTERNAL CAUSE WAS 206 DESCRIBE HOW INJURY OCCURRED PRIMARY OF CONTRIBUTING	(Enter nature of injury in Part I or Part I of term 18)				
MEDICAL EXAMINER: The certific service the certific director. Page 4 should be foined for your files IMECTUR: Page 3 should to buriol, cremation, or recognitions.	CAUSE OF DEATH					
brcal Examiner: se execute the certivetor. Page 4 should need for your files IECTUR: Page 3 shou buriof, cremation, o	20c. T.ME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e Pl	LACE OF IN.URY (Home, form, 20f (City or town) (County) (State)				
AAM e the the the the the the the the the t	Hour o.m. p.m. 19 While of work of work	ictory, street, office bldg , etc)				
L EXA ecute Poge or you R: Pagi	21 Certify that took charge of the remains described above, I	neld an Autopsy , Inspection X, Inquiry X and in my opinion				
MEDICAL EXA leose execute director. Page foined for you IMECTUR: Page to buriol, cren	death resulted from Natural courses X Accident . Su					
sse est entre in e	A Comment of the comm	CHIEF MEDICAL EXAMINER				
Arrest dr.	SIGNATURE LAND	M.D. ASSISTANT MEDICAL EXAMINER				
TO DEPUTY MEDICAL EXAM necessary, please execute the funeral director. Page 45 may be retoined for your TO INNEMAL PLECTUR: Page Health prior to buriol, crema	EXAMMER'S Earl L. Royer, M.D.	DEPUTY MED CAL EXAM NER X 10-27-67				
O DEPUTY necessary, the funero 5 may be 0 LINEAL						
o D The The Heol	230 BURIAL (REMATION, 236 DATE THEREOF 23c NAME OF CEMETERY O	R CREMATORY 23d LOCATION (City or Town) (County) (State)				
525-	Burial 10/28/67 Farlow's C	Cemetery rural Pittsville, Md.				
VR A15ME (5)	24 FUNGRAL DRECTOR ADDRESS	250 REC'D BY REGISTRAR 255 ASCINTRARS ASNA 13 PE				
6M 1/67	A Willis Wills Chestertown	1, Md. DAOCT 3 1 196/				
30.						



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14678CERTIFICATE OF DEATH led in by the funeral papers. Pages 1 and 2 and 2 and 72 hours after death. 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE o. COUNTY Wicomico MARYLAND Marvland Wicomico b CITY OR TOWN (f outside corporate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Salisbury 1 mc
d. NAME OF MOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Salisbury 1 mon. B IS RESIDENCE ON A FARM? d STREET ADDRESS Sopers. NO 🎤 Wicomico Nursing Home requires that the death certificate be executed within 3 NAME OF Middle 4. DATE Month FIFST Lost Day Year carbon physician and completely DECEASED CARL 10 18 HENRY SMITH, SR. 19 67 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 6 COLOR OR RACE NEVER MARRIED B. DATE OF BIRTH AGE (In years 7 MARRIED lost birthdoy) 83 yrs. Months Hours DIVORCED White WIDOWED Aug. 10, 1884 Male 10o USLAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) INDUSTRY COUNTRY? Maryland -- Wicomico U.S.A Ret. Farmer Truck 14. MOTHER'S MAIDEN NAME MARIA 13. FATHER'S NAME Robert Smith WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT signed by the attendi burial-transit permit. (Yes, no, or unknown) (If yes give war or dates of service) 3Dr. Wm. B. Smith Salisbury, Maryland NO. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b); and (c))
PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse by the haspital ar attending os the O FUNERAL DIRECTOR: After this certificate has been WAS AUTOPS)
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO far 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. 20d INJURY OCCURRED foctory, street, office bldg., etc.) Not While ot work at wark 21. 1 certify that (I) (this hospital) attended the deceased from director, page 3 should should be filed with the 7 and that death accurred at 3/5 M. from couses and on the date stated above. saw the deceased alive an______ 22b. DATE SLONED 22o SIGNATURE ATTENDING DIRECTOR PHYS. 22d. ADDRESS 22c PHYSICIAN'S 402 S. Division St., Salisbury, Maryland NAME (Type) William B. Smith M.D. 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) BURIAL, CREMATION. Salisbury, Maryland 10/21/1967 Wico. Mem. Park 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE ADDRESS FUNERAL DIRECTOR VR A15 (4) Salisbury, Maryland 20 M 1/66



1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201						
	14679 CERTIFICATE OF DEATH						
ī	PLACE OF DEATH a. COUNTY Wicomico MARYLAND 2 USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) a. STATE b. COUNTY b. COUNTY wicomico	_					
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town) Write RURAL and give neorest town) Salisbury C. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town) Salisbury	}					
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Peninsula General Hospital d. STREET ADDRESS d. STREET ADDRESS Peninsula General Hospital 402 Woodcrest YES NO						
3	NAME OF First Middle Lost 4 DATE Month Day Year OF OF DECEASED (Type or print) JOHN WOLFE Stout Sr. DEATH October 15 19 4	7					
L	SEX 6. COLOR OR RACE 7. MARRIED AND NEVER MARRIED B DATE OF BIRTH 9 AGE (n years funder 14 A form) B Date of Birth 1-12-1891 70 yrs Months Days Haurs Mi	-					
q	10. USUAL OCCUPATION (Give kind of work done uring most of working 1 le, even if retired) 10. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? COUNTRY? Kingston, New Jersey 13. CITIZEN OF WHAT COUNTRY?						
	3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Mary Wolfe						
(S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 214-10-9664 Mrs. Blossom C. Stout, See Sec. 2						
	18. CAUSE OF DEATH (Enter only one couse per line for (b), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse (b) Lost. (c) INTERVAL BETWEEN ONSELAND DEATH ONSELAND ACAIL April 1 Death Was Caused BY: Until 1 Death Was Caused BY: ONSELAND ACAIL ONS	1					
ATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES \ NO						
MEDICAL CEDITORATION	20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)						
MEDICA	p.m. 17 of work — of work — j						
	21. I certify that (1) (this haspital) attended the deceased from 10 etables 12, 1967, to 50 tables 15, 1962, that (1) (we) lo sow the deceased olive an other 15 1967, and that death occurred at 3 2 M, from causes and on the date stated above						
l	22a, SIGNATURE M.D. ATTENDING MED. STAFF PHYS. 22b. DATE SIGNED 22c. DATE SIGNED 2						
	NAME (Type) Nevias W. Todd Medical Lester - Salisbury, Marylan	20					
L	36. BURIAL (REMATION, REMOVAL (Specify) Burial 10-18-1967 Manokin Presbyterian Cem. Princess Ann. Maryland						
	24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland ADDRESS ADDRESS DATE OCT 17 1967						

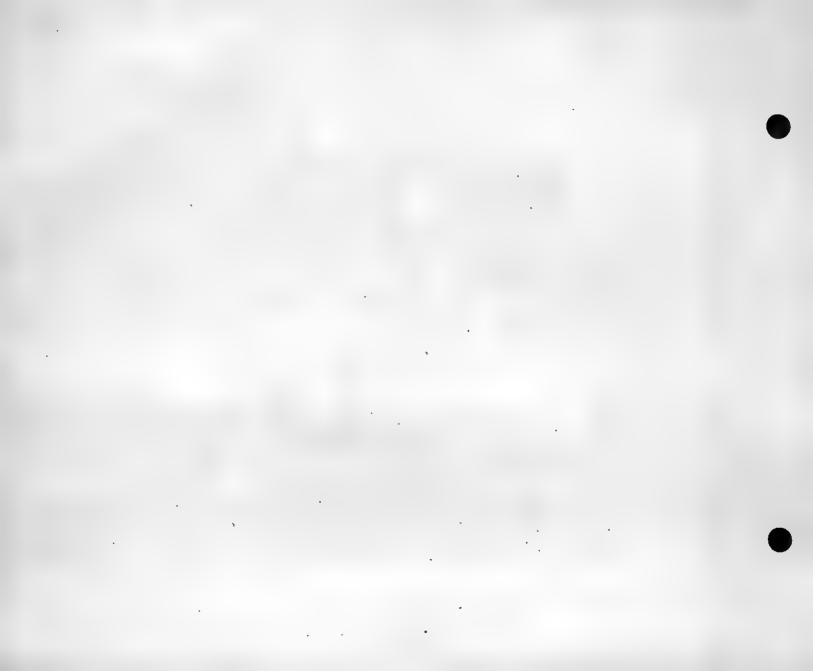


RESEARCH AND RECORDS, 301 W. PRESTON STREET, B ALTIMORE 1, MARYLAND 1. PLACE OF DEATH USUAL RESIDENCE (When, due used I v. d. If institutions Residence before admission e. COUNTY MARYLAND outside corporet. I mits c. LENGTH OF STAY IN 16 OR TOWN (If outside corporete limits, write RURAL and give nearest lown) BALL and persone (get town) va street eddress ON A FARM? YES [] NO [3 NAME OF aTypa or prints Marguerite Ellen 5 SEX AGE (In years HE UNDER TYEAR 7. MARRIED NEVER MARRIED (last birthday) | Months | Days 12. CITIZEN OF WHAT COUNTRY? done during most of working life even if retired) 16 SOCIAL SECURITY NO ills Succeltill Ud, Rt + 1 Roy 8 18. CAUSE OF DEATH (Enter only one cause per line for (e . b , and ,c .) INTERVAL BETWEEN PART - DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which? (b) gave rise to immediate cause DUE TO (a), stating the underlying ceuse lest. PART II OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 8 19. WAS AUTOPSY PERFORMED? NO DE 20b. DESCRIBE HOW INJURY OCCURED (Enter neture of injury an Pert I or Pert II of Item 18) 20a. EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING CAUSE OF DEATH. 20c. TIME OF INJURY Month Day, Yea, 20d. NJJRY OCCURRED 20e, PLACE OF INJJRY (Home, farm, 20f City or town (County) (Stete) factory, streat, offica bldg., etc. While Not While el work et work 21. I certify that I took charge of the remains described above, held an Autopsy . Inspect on noulry X and in my opinion Natura, causes X Suicide Undetermined manner death resulted from. Accident Hom cide CHIEF MEDICAL EXAMINER ACTUAL should be for ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER 10-18-67 ō EXAMINER'S NAME (Type) Health Address (Street, city, fown or county) 228. BURIAL CREMATION T 226. BATE THEREOF 22c FRAME OF CEMETERY OR CREMATORY 22d. LOCAT ON (City, town, or country). (Steta) REMOVAL (Specify) 23. FUNERAL D RECTOR 24e REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE 5M 1/62

DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY in by.
Pages 1. a. STATE b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits. C. LENCTH OF STAY IN 1h c. CITY OR-LOWN (If outside corporate limits, write RURAL and give nearest town) papers. Pági iin 72 hours a write RURAL and (give nearest town) 5 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE filled ON A FARM? within NO X YES etely carbon NAME OF DATE Month Day Middle 4. Last DECEASED event, v 1967 to ber 5 (Type or print) DEATH / and comp SEX 6. COLOR OR RACE ACE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS. | Jast birthday) | Months | Days | Hours | Min. 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. Pemove E WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) .= 10b. KIND OF BUSINESS OR 11. BIRTHPLAKE (County & State, or foreign country) 12. CITIZEN OF WHA the attending physician t permit. Then please ation, or removal, and in þ HNDUSTRY death certificate 13. FATHER'S NAME MOTHER'S MAIDEN NAME 15. WAS DECEASED IVER IN U.S. ARMED FORCES? (Yes, pq. q unkown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. **INFORMAN** Address 17. transit perm cremation, o INTERVAL BETWEEN CAUSE DF DEATH [Enter only one cause per line for (a), The law requires that the been signed by the burial-transit or to burial, crema PART I. DEATH WAS CAUSED BY: attending physician, IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate DUE TO (a), stating prior . underlying cause last. 83 CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELAXED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health PERFORMED? certificate by the hospital or ND YES 2/a. ACCIDENT WAS UNDERLYING TO THE OF CEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ATTENDING PHYSICIAN: 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) detached for the Dept. of 1 this MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) (County) State 1 factory, street, office bldg., etc.) DIRECTOR: After tage 3 should be de Hour a.m. While Not While at work 19 at work p.m. 21. I certify that (I) (this hospital) attended the deceased from that (I) (we) last M, from the causes and on the date stated above. deceased alive on and that death occurred at saw DATE/SICNED 22b. þe page MED. STAFF DIRECTOR PHYS. M.D. O HOSPITAL FUNERAL 22d. **ADDRESS** director, p should be NAME (Type) (State) 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) BURIAL, CREMATION. 23c. REMOVAL (Specify) 0 25a. REC'D BY RECISTRAR 25b. RECISTRAR'S SICNATURE FUNERAL DIRECTOR VR A15 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14673 CERTIFICATE OF DEATH 14683PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) 24 haurs after deal a. COUNTY o. STATE b. COUNTY Wicomico Maryland Worcester MARYLAND b CITY OR TOWN (If autside carparate limits, CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury hours Pocomoke City d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS ON A FARM? Peninsula General Hospital 602 Walnut Street YES NOSES requires that the death certificate be executed within NAME OF First Middle 4. DATE Last Day Year DECEASED OF DEATH GARLAND (Type or print) COL B DATE OF BIRTH AGE (In years 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** please remave Jast orthday) Manths Doys Haurs Oct. WIDOWED DIVORCED 10a USLAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country)
ACCOMACK County. 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? Retail Sales Virginia
14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME signed by the attending phy burial-transit permit Then Thomas Wessells unknown 17 INFORMANT 15 WAS DECEASED EVER IN J.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address City, (Yes, no, ar unknown) (If yes give war or dates af service) 213-05-2014 Mrs Eva R. Wessells, Maryland 18. CAUSE OF DEATH (Enter only one cause per line far.(o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO Conditions, if any, which gove rise ta immediate cause (a). DUE TO stating the underlying couse Page 4 may be retained by the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been os the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS ALTOPS'
PERFORMED? for use YES T NO 20d ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Day, Year (Stote) foctory, street, office bldg . etc.) Not While at wark 21. 1 certify that (1) (this haspital) attended the deceased fram_ 1947, that (1) (we) last ta. . 0 19.67, and that death accurred at 1532 M, fram causes and an the date stated above. 13 7 saw the deceased alive an_ 22a SIGNATURE 22b. DATE SIGNED MED. DIRECTOR . 0 9.67 M.D. PHYS. 22d ADDRESS 22c PHYSICIAN'S NAME (Type) Medical Center. Salisbury. Md. directar, 23c NAME OF CEMETERY DISCREMANDRY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) (State) 230 BURIAL, CREMATION, Burial (Specify) Pocomoke - Wor. - Md. 10-12-1967 Bethany Methodist 2Sa. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE OCT liselan 1967 Pocomoke City, Md. 20 M 1/66



	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
	~5574	CERTIFICATE	OF DEATH		14684	
1.	PLACE OF DEATH o. COUNTY Wicomico	MARYLAND	2 USUAL RESIDENCE (Where	deceosed lived, if institution R	esidence befare admission)	
	b CITY OR TOWN (If autside carporote limits, SMITS BULLY)	C LENGTH OF STAY IN 16	c (ITY OR TOWN (If outside	corporate Humis, write RURAL and	nd give neorest town)	
	d NAME OF HOSPITAL OR INSTITUTION (If not in Peninsula General	- //	d STREET ADDRESS		B IS RESIDENCE ON A FARM? YES 2 NO	
3	NAME OF DECEASED (Type or print) Collect	Middle (U)	lliams	DATE OF Month OF S	Day Year 19 6 7 INDER 1 YEAR IF UNDER 24 HRS.	
/	n e v	MARRIED NEVER MARRIED DIVORCED DIVORCED	- 15- 14	5 Spurthday) Ma	nths Days Hours Mm.	
dt	a USUAL CCUPATION (Give kind of work done pring most at working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (County & Sto	ico Con	COUNTRY? A	
	FATHER'S NAME	lleons	Centains	ne Kater	to	
crematian, ar remayal, and in any event	5 WA DECEASED EVER IN J.S. ARMED FORCES?	*** 20-28-4634	Lossi	c Willes	INTERVAL BETWEEN	
	18. CAUSE OF DEATH (Enter only one couse p PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	er line for (g), (b), ond (g)	ation	//:	ONSET AND DEATH	
	Conditions, if ony, which gave isset a immediate cause (a), storing the underlying couse DUE TO	Car dias	Just	Lucy	01	
NO	PART II. OTHER SIGNIFICANT CONDITIONS CONTR	RIBUTING TO DEATH BUT NOT RELATED TO 1	THE TERMINAL DISEASE CONDITION	ON GIVEN N PART (6)	19. WAS AUTOPSY PERFORMED? YES NO	
CERTIFICATION	200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CIFETTHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED.	Enter nature of injury in Port	l or Part II of item 18)	YES NO L	
MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour a.m. 19	20d. INJURY OCCURRED While Not While of work of work	CE OF INJURY (Home, form, ory, street, office bldg., etc.)	20f. (City ar tawn)	(Caunty) (State)	
	21. I certify that (I) (this haspite saw the deceased alive an	al) attended the deceased fram	death accurred at 10	55 M, fram causes and	, 196/, that (I) (we) las an the date stated above	
	220. SIGNATURE	& Suith M.	11111	CTOR PHYS.	2b. DATE SIGNED	
	22c PHYSICIAN'S NAME (Type)		22d. ADDRESS	A	/ / /	
ηĿ	30 BORIAL CREMATION, 23b DATE THEREO	67 Kriew 1	teres !	23d ROCATION (City or Town) ALLS LUTY REGISTRAR -25b. REGIST	(County) (Stote)	
1	PAL FUNERAL DIRECTOR	ADDRESS	2So. REC'D BY	I 6 1967	issely Judge	





Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14676 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 14686 HEALTH DEP PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Poge 9 Baltimore-City Wicomico Maryland MARYLAND delay and 3 t ote Department b. CITY OR TOWN (If autside corporate limits. C LENGTH OF STAY IN 15 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) P.M3. write RURAL and give negrest town) Baltimore Hebron d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? Lillian & Main Streets 617 W. 40th Street Corner in Item 18. Give Poges YES NO X 24 hours ofter deoth. pending" in pencil in Item 18. Give Pog ef Medical Exominer's Office along with 3. NAME OF First Middle DATE Lost Month Day Year DECEASED the 28 THOMAS NORWOOD WILSON within October 67 (Type or print) 19 DEATH with S SEX IF UNDER 1 YEAR 6. COLOR OR RACE 7 MARRIED K NEVER MARRIED 8. DATE OF BIRTH AGE (In years IF LINDER 24 HRS last birthday) Months Davs Hours White April 19, 1899 Male WIDOWED DIVORCED event and 2 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Mary land any pencil i 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within = William Roy Wilson Cora V. Nelson a pup Mrs. Frances A. Wilson (Wife) 617 W. 40th Street, Baltimore 11, Md. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, ar unknown) (If yes give war ar dates of service) or removol, 219-34-0676A 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN buriol-transit PART I, DEATH WAS CAUSED BY SEL AND DEATH Coronary occlusion IMMEDIATE CAUSE (a) 4201 word This certificate should cremation, DUE TO forwarded to the Canditians, if any, which gave Arteriosclerotic cardiovascular disease Years rise ta immediate cause (a). DUE TO storing the underlying couse 0 90 last. burial, a nsed 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 2 the certificate, 0 NO X YES pe 20g. EXTERNAL CAUSE WAS ogent, prior 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) should PRIMARY ar CONTRIBUTING **EXAMINER:** CAUSE OF DEATH. 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (Stote) factory, street, office bldg., etc.) Not While pleose execute at wark at work designoted 21. I certify that I taak charge of the remains described above, held an Autapsy Inspection X Inquiry X and in my apinian may be retained for FUNERAL DIRECTOR: the funeral director. Natural causes X death resulted from Undetermined manner Accident Suicide Hamicide | CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE 10 DEPUTY MEDICAL EXAMINER X October Earl L. Royer, M. 1 409 Cemden Ave., Salisbury, Md. EXAMINER'S Health (NAME (Type) Address (Street, city, lown, or county) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 90 REMOVAL (Specify) Druid Ridge Cemetery Baltimore, Maryland Nov. 1, 1967 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR Ochorles VR A15ME (5) HOLLOWAY & COMPANY, SALISBURY, MARYLAND 6M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 14687 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY 6. QUNTY DROESTER Wicomico MARYLAND RVCANO 24 haurs afte b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) BRUIN Salisbury filled in e. IS RESIDENC d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS paper ON A FARM? YES NO DA Peninsula General Hospital The law requires that the death certificate be executed within NAME OF 4. DATE Middle Month lost Doy Year the attending physician and completely sit permit. Then please remaye carbo DECEASED OBER ROUGH 19 6 (Type or print) DEATH S. SEX AGE (In years 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED DATE OF BIRTH last birthday) Months Days Hours and in any WIDOWED DIVORCED KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 11. RIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY SERVIN JISNESS WELDER 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ROUGH WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na ar unknown) (If yes give war ar dates of service) BERLIN 1B. CAUSE OF DEATH (Enter only one cause per line fgr (o), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital or attending as the O FUNERAL DIRECTOR: After this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) USe NO F far 20b. DESCRIBE HOW INJURY OCCURRED. (Enfer nature of injury in Part I or Part II of Nem 18.) 20a. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) factory, street, office bldg., etc.) Not While 19 at work þ 21. I certify that (1) (this hospital) ottended the deceased from 10 - 22 196210 10-23 19.6 ? that (1) (we) last 196. 2, and that death accurred at 10 2M, from causes and on the date stated above. saw the deceased alive an_ 10-23 220. SIGNATURE 22b. DATE SIGNED 10-23-67 M.D. PHYS. DIRECTOR PHYS. , page be filed 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) director, should b 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 230. BURIAL, CREMATION, 23b. DATE THEREOF (County) REMOVAL (Specify) VERGREEN 25b. REGISTRAR'S SIGNATUR 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4 20 M 1/66